

F. A. Washburn

ELEVENTH ANNUAL CONFERENCE

American
Hospital Association

Nineteen Hundred and Nine
WASHINGTON, D. C.

Vol. XI.



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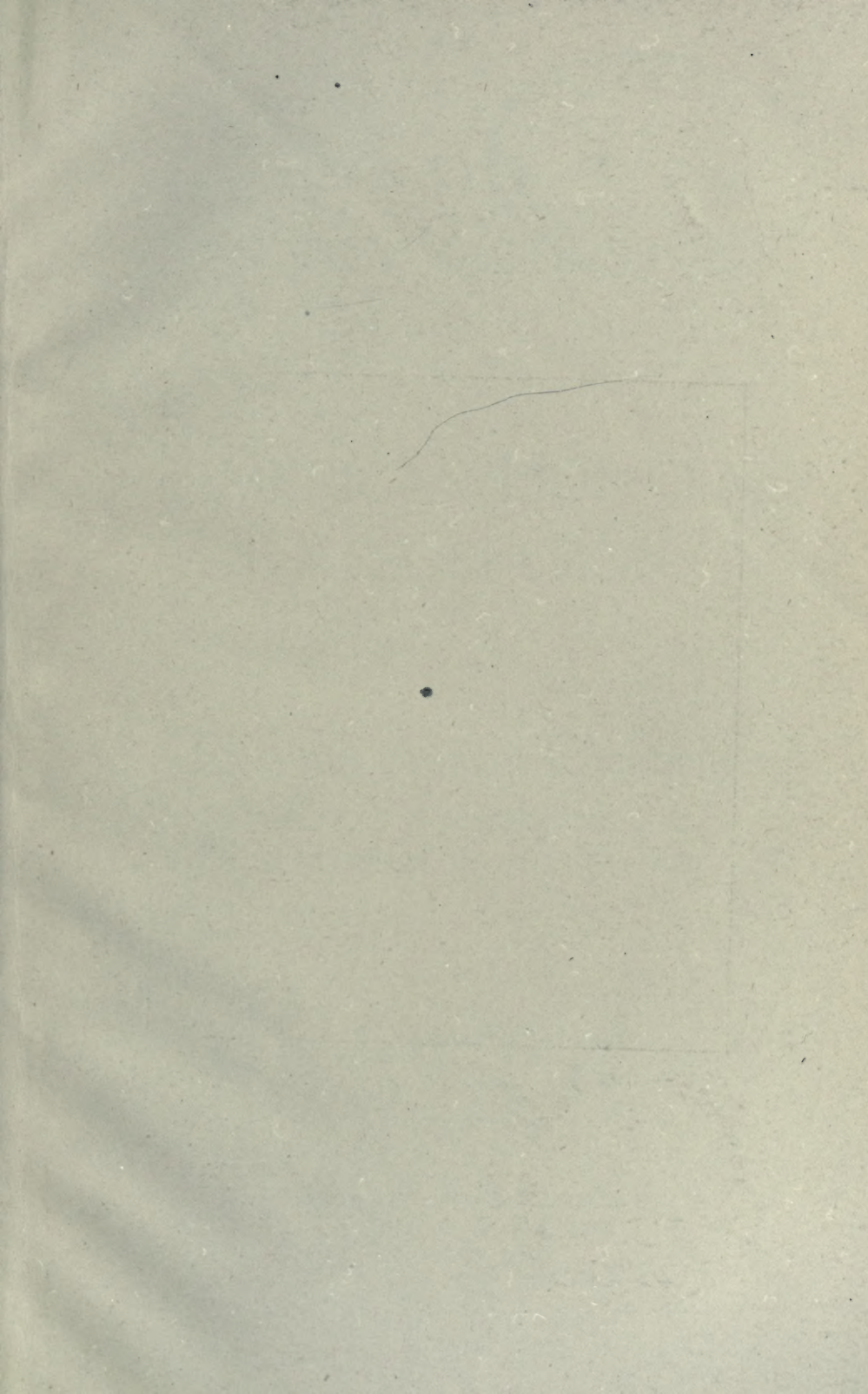
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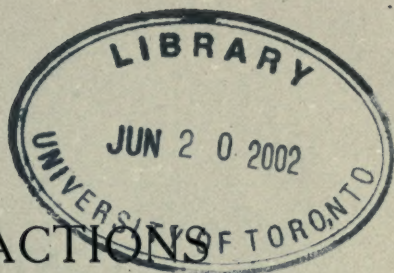
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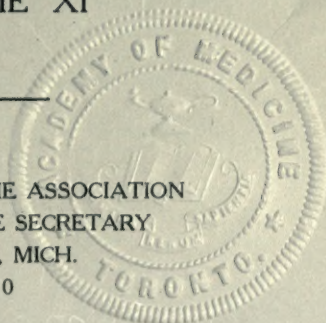
Eleventh Annual Conference

HELD AT WASHINGTON, D. C.
SEPTEMBER 21, 22, 23, 24, 1909

VOLUME XI

PUBLISHED BY THE ASSOCIATION
OFFICE OF THE SECRETARY
DETROIT, MICH.

1910



CONTENTS.

Officers and Committees, 1908-9, 1909-10.....	3-8
Alphabetical List of Members.....	9-83
Honorary Members	84
Constitution and By-Laws.....	85
Minutes of the Eleventh Annual Conference.....	92
Invocation, Rev. G. C. F. Bratenahl.....	92
Address of Greeting, Surgeon-General P. M. Rixey, U. S. A.	94
President's Address, J. M. Peters, M. D.....	138
Administration of Military Hospitals.....	153
The Hospital from the Patient's Point of View, W. Gilman Thompson, M. D.....	160
The Many-Sidedness of Hospital Work, Homer Folks, Esq..	166
The Hospital and the Public, Del T. Sutton, Esq.....	176
The Hospital and the Patient of Moderate Means, Frederick Brush, M. D.....	181
Cost Accounting in Hospitals, Dr. Thoms Howell.....	193
The Terraced Pavilion, Dr. D. Sarason.....	217
The Appropriation of Public Funds for the Partial Support of Voluntary Hospitals in the United States and Canada, S. S. Goldwater, M. D.....	242
Random Suggestions Regarding Hospital Construction and Management, Dr. R. W. Corwin.....	295
The Relationship Between the Architect and Doctor in Plan- ning a Hospital, Charles P. Emerson, M. D.....	305
Description of the New Naval Hospital, Rear Admiral A. Ross	318
Report of the Committee on Hospital Construction, Dr. H. B. Howard	333
What Do Justice and Present Conditions Demand in the Way of Law and Education for Nurses, R. M. Phelps, M. D..	345
Report of Special Training School Committee.....	361
The Value of Medical Schools to Hospitals, Dr. Rupert Norton	401
Report of the Committee on Hospital Progress, Dr. R. R. Ross	411
Report of Committee on Uniform Accounting, Dr. Geo. F. Clover	426
Index	436

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The Macon Hospitals, Macon, Ga. (*Associate*)
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Western Maryland Hospital, Cumberland, Md.
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Female Hospital, St. Louis, Mo.
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Rockefeller Institute Hospital, New York City.
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Provincial Hospital, Kentville, N. S.
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National Soldiers' Home, Togus, Me.
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Onondaga County Hospital, Onondaga, N. Y.
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Corry Hospital, Corry, Pa.
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N. Y. Medical College and Hospital,
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Southern Kentucky Sanatorium, Franklin, Ky.
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Jackson City Hospital, Jackson, Mich. (*Associate*)
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Rhode Island State Hospital for Insane,
Providence, R. I.
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West Side Hospital, Scranton, Pa.

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Eye, Ear and Throat Charity Hospital,
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Worcester Isolation Hospital, Worcester, Mass.
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Boston City Hospital, Boston, Mass. (*Associate*)
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German Hospital, San Francisco, Cal.
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Rochester State Hospital, Rochester, N. Y.

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697 Huntington Ave., Boston, Mass.
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New York Hospital, New York City.
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Amsterdam City Hospital, Amsterdam, N. Y.
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Asylum for Insane Indians, Canton, S. D.
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Cottage State Hospital, Mercer, Pa.
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Johns Hopkins Hospital, Baltimore, Md.
- ARTHUR W. HURD, M. D., Supt., (1905)
Buffalo State Hospital, Buffalo, N. Y.
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Orange Memorial Hospital, Orange, N. J.
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Memorial Hospital, Worcester, Mass.
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Memorial Hospital, Niagara Falls, N. Y.

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Homeopathic Hospital, Washington, D. C.
(Associate)
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Rochester Homeopathic Hospital, Rochester, N. Y.
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Home for Incurables, Fordham, N. Y.
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Los Angeles Hospital, Los Angeles, Cal.
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Roper Hospital, Charleston, S. C.
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University Hospitals, Minneapolis, Minn.
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Contagious Disease Hospital, Chicago, Ill.
- REV. A. S. KAVANAGH, D. D., Supt., (1908)
Methodist Episcopal Hospital, Brooklyn, N. Y.
- MRS. J. A. KEHLBECK, Trustee, (1908)
The Jamaica Hospital,
2195 Broadway, New York City.
- MISS MARY L. KEITH, Supt., (1905)
Rochester City Hospital, Rochester, N. Y.
- MISS LYDIA H. KELLER, Supt., (1907)
Cobb Hospital, St. Paul, Minn.
- J. H. KELLOGG, M. D., Supt., (1910)
Battle Creek Sanatorium, Battle Creek, Mich.
- MISS ELEANOR KELLY, Supt., (1909)
St. Luke's Hospital, Kansas City, Mo.
- GEO. B. KELSO, Supt., (1909)
Kelso Sanatorium and Hospital, Bloomington, Ill.
- W. B. KENDALL, Supt., (1909)
Cottage Sanatorium, Gravenhurst, Ont.
- WALLACE W. KENNEY, Supt., (1905)
Victoria General Hospital, Halifax, N. S.
- WM. C. T. KERGIN, M. D., Supt., (1909)
Port Simpson General Hospital,
Port Simpson, B. C.

- A. K. KESSLER, M. D., Supt., (1903)
Kessler Hospital, Clarksburg, W. Va.
- H. B. KILDAHL, Supt., (1907)
Norwegian Lutheran Hospital, Chicago, Ill.
- WALTER C. G. KIRCHNER, M. D., Supt., (1907)
City Hospital, St. Louis, Mo.
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Asbury M. E. Deaconess Hospital and Home,
Minneapolis, Minn.
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Newark German Hospital, Newark, N. J.
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1110 W. 12th St., Des Moines, Iowa.
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German Hospital and Dispensary, New York City.
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Frederick Ferris Thompson Hospital.
Canandaigua, N. Y.
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128 Duane St., New York City.
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New York City.
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Jersey City Hospital, Jersey City, N. J.
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Levering Hospital, Hannibal, Mo.
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University of Kansas Hospital, Lawrence, Kan.
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State Hospital, Hazelton, Pa.

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General Memorial Hospital, New York City.
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City Hospital, Akron, O.
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Ravenswood Hospital, Chicago, Ill.
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Holy Cross Hospital, Salt Lake City, Utah.
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Augusta City Hospital, Augusta, Ga.
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Roxborough, Philadelphia, Pa.
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Garfield Memorial Hospital, Washington, D. C.

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Sara Leigh Hospital, Norfolk, Va.
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- MISS MARGARET S. PARK, Supt., (1907)
North Bay Hospital, North Bay, Ont.
- J. H. S. PARKE, Supt., (1907)
Montreal General Hospital, Montreal, Que.
- MISS ANNA CHANDLER PARKER, Supt., (1905)
Hale Hospital, Haverhill, Mass.
- REED PARKHURST, Assistant Supt., (1908)
Muskegon County Hospital, Muskegon, Mich.
(*Associate*)
- MISS MARION G. PARSONS, Assistant Supt., (1909)
City and County Hospital, San Francisco, Cal.
(*Associate*)
- MISS ADAH H. PATTERSON, Supt., (1908)
St. Luke's Hospital, St. Paul, Minn.
- MISS JEANETTE M. PAULUS, (1907)
1003 Luttrell St., Knoxville, Tenn.
- MISS ESTHER PEARSON, Supt., (1909)
Iowa Methodist Hospital, Des Moines, Iowa.
- T. S. PENDERGASS, Supt., (1908)
Saint Mark's Hospital, Salt Lake City, Utah.
- J. P. PERCIVAL, M. D., Supt., (1909)
Norfolk Hospital for the Insane, Norfolk, Neb.
- JOHN M. PETERS, M. D., Supt., (1901)
Rhode Island Hospital, Providence, R. I.
- MRS. ERNESTINE PETERSEN, Supt., (1907)
Red Cross Sanatorium, Rock Island, Ill.
- MISS ELIZABETH PETERSON, Supt., (1908)
Swedish Hospital, Minneapolis, Minn.
- A. W. PETT, M. D., Supt., (1908)
Wage Earners' Emergency Hospital,
Providence, R. I.

- MISS CLARA D. PETTIT, Assistant Supt., (1904)
Santa Fe Hospital, Los Angeles, Cal. (*Associate*)
- MARY B. PHELAN, Asst. Supt., (1908)
De Soto Sanatorium, Jacksonville, Fla. (*Associate*)
- R. M. PHELPS, M. D., Assistant Supt., (1909)
Rochester State Hospital, Rochester, Minn.
(*Associate*)
- MISS GRACE G. PILLSBURY, Supt., (1905)
Addison Gilbert Hospital, Gloucester, Mass.
- CELESTINO PIVA, Pres., (1908)
Italian Benevolent Institute and Hospital,
167 W. Houston St., New York City.
- F. G. PLATT, Trustee (1908)
New Britain General Hospital, New Britain, Conn.
- WALTER B. PLATT, M. D., Supt., (1908)
Robert Garrett Hospital for Children,
Baltimore, Md.
- MISS VIRGINIA PORTER, Supt., (1909)
Mercy Hospital, Kansas City, Mo.
- HERMAN PRETZINGER, Trustee, (1908)
Miami Valley Hospital, Dayton, O.
- GEO. M. PRICE, Trustee, (1908)
Hospital of the Good Shepherd,
412 S. Warren St., Syracuse, N. Y.
- MISS IDA E. PROCTOR, Supt., (1906)
General Hospital, Saginaw, Mich.
- JOSEPH PURVIS, (1907)
243 S. Kenilworth St., Oak Park, Ill.
- A. J. RANNEY, M. D., Supt., (1905)
Lakeside Hospital, Cleveland, O.
- J. M. RATLIFF, M. D., Supt., (1909)
Dayton Sanatorium, Dayton, O.
- W. J. RICKARD, Assistant Supt., (1907)
Bellevue Hospital, New York City. (*Associate*)
- MISS MARY H. RIDDLE, Supt., (1905)
Newton Hospital, Newton, Mass.

- B. D. RIDLON, M. D., Supt., (1907)
National Home for Disabled Volunteer Soldiers,
Togus, Me.
- MISS ANNA M. RINDLAUB, Supt., (1909)
South Side Hospital, Pittsburg, Pa.
- BERNARD RIPPIN, Assistant Supt., (1909)
Sydenham Hospital, New York City.
(Associate)
- GEO. L. RIVES, Trustee, (1909)
New York Hospital, New York City.
- B. J. ROBERTS, Supt., (1909)
Texas Baptist Memorial Hospital, Dallas, Tex.
- DONALD M. ROBERTSON, M. D., Supt., (1908)
Co. of Carleton General Protestant Hospital,
Ottawa, Ont.
- J. ROSS ROBERTSON, Pres. Board of Trustees, (1907)
Hospital for Sick Children, Toronto, Ont.
- THOMAS K. ROBERTSON, Assistant Supt., (1907)
New York Hospital, New York City. (Associate)
- MISS AUGUSTA C. ROBERTSON, Supt., (1905)
Elliot Hospital, Manchester, N. H.
- G. WILSE ROBINSON, M. D., Supt., (1909)
Kansas City General Hospital, Kansas City, Mo.
- MISS MARGARET ROGERS, Supt., (1909)
The Jewish Hospital, St. Louis, Mo.
- SISTER M. ROSE, Supt., (1908)
St. Elizabeth's Hospital, Boston, Mass.
- RENWICK R. ROSS, M. D., Supt., (1904)
Buffalo General Hospital, Buffalo, N. Y.
- MRS. MARY ELY ROTHROCK, Supt., (1909)
The Union Hospital, Fall River, Mass.
- GEO. H. M. ROWE, M. D., (1901)
Boston City Hospital, Boston, Mass.
- W. E. ROWLEY, M. D., Supt., (1907)
General Hospital, St. Johns, N. B.
- A. L. RUSSELL, Trustee,
R. M. and General Hospital, Port Arthur, Ont.

- SISTER ST. JAMES, Superior, (1908)
City Hospital, Ogdensburg, N. Y.
- E. W. SAUNDERS, M. D., Supt., (1903)
Bethesda Hospital, St. Louis, Mo.
- GEO. F. SAUER, Supt., (1909)
Home of Rest for Consumptives,
Bolton Road, New York City.
- F. M. SCHULZ, M. D., Supt., (1908)
Milwaukee County Hospital, Wauwatosa, Wis..
- MISS ANNA L. SCHULZE, Supt., (1908)
Saratoga Hospital, Saratoga Springs, N. Y.
- MISS MARY SCHUMACKER, Supt., (1906)
Sanatorium Hospital, Troy, N. Y.
- DAVID SCHWAB, Supt., (1908)
The Hebrew Hospital, Baltimore, Md.
- ALICE M. SEABROOK, M. D., Supt., (1902)
Women's Hospital, Philadelphia, Pa.
- MISS HANNAH F. SEARCY, Supt., (1905)
Milford Hospital, Milford, Mass.
- RALPH B. SEEM, M. D., Supt., (1909)
Jas. Walker Memorial Hospital, Wilmington, N. C.
- MISS M. T. SHACKLEFORD, Supt., (1908)
Pittman Hospital, Tarboro, N. C.
- NEWTON M. SHAFFER, M. D., Supt., (1909)
N. Y. State Hospital for Crippled and Deformed
Children, New York City.
- MISS KATHERINE M. SHALTO, Assistant Supt., (1909)
National Soldiers' Home, Tennessee. (*Associate*)
- MISS FRANCES SHARPE, Supt., (1909)
General Hospital, Woodstock, Ont.
- HOBART P. SHATTUCK, M. D., Supt., (1909)
Whitwell Hospital, Tucson, Ariz.
- MISS MARY R. SHAVER, Supt., (1907)
Good Samaritan Hospital, Lexington, Ky.
- RICHARD E. SHAW, M. D., Supt., (1901)
Long Island College Hospital, Brooklyn, N. Y.
- MOTHER SEBASTIAN SHEA, Supt., (1903)
St. Mary's Hospital, Pueblo, Colo.

- C. C. SHELDON, M. D., Supt., (1904)
Lynn Hospital, Lynn, Mass.
- MISS IDA F. SHEPARD, Supt., (1905)
Mary Hitchcock Hospital, Hanover, N. H.
- L. J. SHEPPARD, Supt., (1907)
B. & W. Hospital, Berlin, Ont.
- MISS JESSIE M. SHERATON, Supt., (1905)
Aberdeen Hospital, New Glasgow, N. S.
- FLORENCE BROWN SHERBON, M. D., Supt., (1909)
Victoria Sanatorium, Colfax, Iowa.
- MISS GERTRUDE SHIELDS, Supt., (1908)
Almonte Victoria Hospital, Almonte, Ont.
- L. C. SHINGLE, Supt., (1909)
Roosevelt Hospital, Berkeley, Cal.
- MISS STELLA SHIPLEY, Supt., (1909)
Bartlesville Hospital, Bartlesville, Okla.
- A. B. SIMONSON, M. D., Supt., (1909)
Calumet & Hecla Hospital, Calumet, Mich.
- CHAS. E. SIMPSON, M. D., Supt., (1904)
Lowell Hospital, Lowell, Mass.
- MISS S. A. SIMS, Supt., (1904)
Youngstown Hospital, Youngstown, O.
- J. O. SKINNER, M. D., Supt., (1904)
Columbia Hospital, Washington, D. C.
- CLARENCE E. SKINNER, M. D., Supt., (1909)
Elm City Private Hospital, New Haven, Conn.
- MISS IMOGENE SLADE, Asst. Supt., (1909)
Woonsocket Hospital, Woonsocket, R. I.
(Associate)
- MISS LAURA A. SLEE, Supt., (1900)
Women's and Children's Hospital, Syracuse, N. Y.
- MISS ANNE C. SMITH, Supt., (1908)
Guelph General Hospital, Guelph, Ont.
- CHAS. D. SMITH, M. D., Supt., (1905)
Maine General Hospital, Portland, Me.
- J. H. SMITH, Pres., (1908)
St. Luke's Hospital, Cedar Rapids, Ia.

- JOHN M. SMITH, Supt., (1908)
Grant Hospital, Columbus, O.
- J. WILLIAM SMITH, Trustee, (1908)
Hospital of the Good Shepherd, Syracuse, N. Y.
- MISS MARY AGNES SMITH, Supt., (1908)
Babies' Hospital, New York City.
- MISS MARY E. SMITH, Supt., (1907)
Columbia Hospital, Pittsburg, Pa.
- WAYNE SMITH, M. D., Supt., (1908)
Washington University Hospital and Dispensary,
St. Louis, Mo.
- WINFORD H. SMITH, M. D., Supt., (1906)
Bellevue Hospital, New York City.
- A. W. SMITH, M. D., Supt., (1909)
Hartford Hospital, Hartford, Conn.
- H. M. SMITH, M. D., Supt., (1909)
N. M. A. I. Hospital, East Las Vegas, New Mex.
- MISS V. THERESA SMITH, Supt., (1909)
California Woman's Hospital, San Francisco, Cal.
- HARRY E. SMITH, Supt., (1909)
Baguio Division Hospital, Baguio, Benguet, P. I.
- MISS EMMA M. SMITH, Supt., (1909)
Jordan Hospital, Plymouth, Mass.
- P. G. SMITH, M. D., Supt., (1909)
Tuberculosis Hospital, Washington, D. C.
- MISS CLARA F. SOLLENBERGER, Supt., (1909)
Coatesville Hospital, Coatesville, Pa.
- EDWARD P. SPARKS, M. D., Supt., (1907)
Miners' Hospital No. 2, McKendree, W. Va.
- JAMES F. SPEER, Supt., (1909)
Homeopathic Hospital, Pittsburg, Pa.
- W. H. SPILLER, M. D., Supt., (1908)
New York Lying-in Hospital, New York City.
- SISTER INGEBORG SPOULAND, Supt., (1907)
Norwegian Lutheran Deaconess' Hospital,
Chicago, Ill.
- MISS JEWEL V. STAFFORD, Supt., (1909)
Muskogee Hospital, Muskogee, Okla.

- SISTER M. STANISLAUS, Supt., (1908)
Mercy Hospital, Wilkesbarre, Pa.
- A. A. STARBUCK, M. D., Supt., (1909)
Wesson Memorial Hospital, Springfield, Mass.
- REV. W. S. STEEN, Supt., (1902)
Presbyterian Hospital, Philadelphia, Pa.
- MISS SOPHIA F. STEINHAUER, Supt., (1907)
Speers Memorial Hospital, Dayton, Ky.
- MISS MARY E. STELLING, Supt., (1908)
Anderson County Hospital, Anderson, S. C.
- MISS WINIFRED L. STEVENS, Supt., (1909)
The Clinton Hospital, Clinton, Mass.
- EDWARD F. STEVENS, Member Hosp. Com., (1909)
N. E. Deaconness' Hospital, Boston, Mass.
(Associate)
- D. A. STEWART, M. D., Trustee, (1909)
Ninette Sanatorium, Winnipeg, Man.
- MISS ELLEN STEWART, Supt., (1907)
Galesburg Hospital, Galesburg, Ill.
- MISS MARY C. STEWART, Supt., (1908)
Marion Sims Hospital, Chicago, Ill.
- EWELL STOCKDALE, M. D., Supt., (1902)
Sunny Rest Sanatorium, White Haven, Pa.
- J. EDWARD STOHLMANN, M. D., Supt., (1906)
N. Y. Infant Asylum, New York City.
- LYDIA WEBSTER STOKES, M. D., Supt., (1909)
Women's Southern Homeopathic Hospital,
Philadelphia, Pa.
- CHAS. STOVER, M. D., Trustee,
Amsterdam City Hospital, Amsterdam, N. Y.
- C. EUGENE STRASSER, Supt., (1907)
Jewish Hospital, Brooklyn, N. Y.
- JOS. V. STRAUB, Trustee, (1908)
German Hospital,
2310 Harrison St., Kansas City, Mo.
- J. R. STUART, M. D., Trustee, (1908)
Houston Infirmiry Sanatorium, Houston, Tex.

- WM. B. SUMMERALL, M. D., Supt., (1909)
Grady Memorial Hospital, Atlanta, Ga.
- H. T. SUMMERSGILL, M. D., Supt., (1909)
New Haven Hospital, New Haven, Conn.
- REV. PAUL F. SWETT, Supt., (1909) .
St. John's Hospital, Brooklyn, N. Y.
- FREDERICK SYMINGTON, Supt., (1904)
William W. Backus Hospital, Norwich, Conn.
- CHAS. E. TALBOT, Supt., (1904)
Newark City Hospital, Newark, N. J.
- WAIT TALCOTT, Secretary, (1908)
Rockford Hospital Association, Rockford, Ill.
- MISS MARJORIE M. TAYLOR, (1908)
42 Brownfield Rd., West Summerfield, Mass.
- MISS MARY J. TAYLOR, Supt., (1908)
Homeopathic Hospital, Albany, N. Y.
- STELLA M. TAYLOR, M. D., Supt., (1903)
New England Hospital for Women, Boston, Mass.
- MISS ELIZABETH C. TAYLOR, Act. Asst. Supt., (1909)
Columbia Hospital, Washington, D. C.
(Associate)
- DANIEL D. TEST, Supt., (1900)
Pennsylvania Hospital, Philadelphia, Pa.
- MISS MARY M. THOMPSON, Asst. Supt., (1909)
F. F. Thompson Memorial Hospital,
Canandaigua, N. Y. (Associate)
- CHAS. E. THOMPSON, M. D., Supt., (1909)
Scranton Private Hospital, Scranton, Pa.
- CHAS. E. THOMPSON, M. D., Supt., (1909)
State Colony for the Insane, Gardner, Mass.
- GEO. TIMMINS, Trustee, (1908)
Hospital of the Good Shepherd,
1410 E. Genesee St., Syracuse, N. Y.
- J. G. TIMOLAT, Trustee, (1909)
S. R. Smith Infirmary, Staten Island, N. Y.
- MISS H. G. TOLMIE, Supt., (1907)
J. H. Stratford Hospital, Brantford, Ont.

- RICHARD H. TOWNLEY, Supt., (1904)
Lincoln Memorial Hospital, New York City.
- HOWARD TOWNSEND, Trustee, (1908)
New York Hospital,
32 Nassau St., New York City.
- L. G. TOWNSHEND, Supt., (1907)
Columbia Hospital, Columbia, Pa.
- MISS ANNIE M. TRIPPE, (1908)
Portage La Prairie, Manitoba.
- PHILOMON E. TRUESDALE, M. D., Trustee, (1909)
P. E. Truesdale Hospital, Fall River, Mass.
- J. FRANK TRULL, M. D., Supt., (1908)
Trull Hospital, Biddeford, Me.
- MISS ALICE I. TWITCHELL, Supt., (1905)
Passavant Hospital, Jacksonville, Ill.
- GEO. T. TUTTLE, Supt., (1909)
McLean Hospital, Waverly, Mass.
- MRS. RUSSELL TYSON, Supt., (1908)
Children's Memorial Hospital, Chicago, Ill.
- MOTHER VALENCIA, Supt., (1908)
St. Francis Hospital, Hartford, Conn.
- MISS C. P. VAN DER WATER, (1907)
The Grace Hospital, Detroit, Mich. (*Associate*)
- FRANK VAM KLEECK, Trustee, (1908)
Vassar Brothers' Hospital, Poughkeepsie, N. Y.
- MISS ROSE Z. VAN VORT, (1907)
Memorial Hospital, Richmond, Va.
- SIEGFRIED WACHSMANN, M. D., Med. Director, (1909)
Montefiore Home, New York City.
- REV. M. WAHLSTROM, Supt., (1906)
Augustana Hospital, Chicago, Ill.
- MISS LUCY WAITE, Supt., (1908)
Mary Thompson Hospital, Chicago, Ill.
- JOHN B. WALKER, M. D., Managing Director, (1908)
New York City Private Hospital Association,
33 East 33rd St., New York City.
- MISS MARGARET M. WALLACE, (1907)
424 River St., Canon City, Colo.

- MISS MARGARET A. WALLACE, Supt., (1909)
General Hospital, Passaic, N. J.
- MRS. ELDORA H. WARD, Supt., (1904)
Jamaica Hospital, Jamaica, N. Y.
- WM. A. WARFIELD, M. D., Supt., (1909)
Freedmen's Hospital, Washington, D. C.
- F. A. WASHBURN, M. D., Supt., (1904)
Mass. General Hospital, Boston, Mass.
- MISS IDA WASHBURN, Supt., (1908)
Eastern Maine General Hospital, Bangor, Me.
- MRS. L. B. WATERS, Supt., (1907)
Passavant Memorial Hospital, Chicago, Ill.
- MISS GRACE G. WATSON, Supt., (1908)
Children's Memorial Hospital, Chicago, Ill.
- W. H. WEBBER, (1899)
2401 Cedar St., Cleveland, O. (*Associate*)
- H. E. WEBSTER, Supt., (1904)
Royal Victoria Hospital, Montreal, Que.
- MISS R. PHYCHE WEBSTER, Supt., (1908)
Day Kimball Hospital, Putnam, Conn.
- MISS MARY J. WEIR, Supt., (1908)
Braddock General Hospital, Braddock, Pa.
- A. W. WEISMANN, Supt., (1907)
Hahnemann Hospital, New York City.
- MISS CORA J. WELKER, Supt., (1909)
Knowlton Hospital, Columbia, S. C.
- MISS EDITH WELLER, Supt., (1909)
Northern Pacific Hospital, Tacoma, Wash.
- A. H. WELLINGTON, Trustee, (1908)
J. Hood Wright Memorial Hospital,
301 West 106th St., New York City.
- JOHN WELLS, Supt., (1906)
Latter Day Saints' Hospital, Salt Lake City, Utah.
- MISS ELEANOR WESTON, Supt., (1904)
Northwestern Hospital, Minneapolis, Minn.
- MISS FLORENCE L. WETMORE, Supt., (1908)
Flushing Hospital, Flushing, N. Y.

- MISS MARY C. WHEELER, Supt., (1908)
Blessing Hospital, Quincy, Ill.
- J. T. WHITE, M. D., Supt., (1908)
White Sanatorium and National Christian Hospital,
Freeport, Ill.
- RICHARD J. WHITE, Trustee, (1907)
Johns Hopkins Hospital, Baltimore, Md.
- GEO. F. WHITE, M. D., Supt., (1909)
Channing Hospital, Providence, R. I.
- MISS LILLIAN L. WHITE, Supt., (1909)
Samuel Merritt Hospital, Oakland, Cal.
- J. I. WHITTENBERG, M. D., Supt., (1907)
St. John's Eruptive Hospital, Louisville, Ky.
- JULIUS M. WILE, Trustee, (1909)
Rochester City Hospital, Rochester, N. Y.
- WILLIAM G. WILLCOX, Trustee, (1909)
S. R. Smith Infirmary, Tompkinsville, N. Y.
- C. D. WILKINS, M. D., Supt., (1908)
City Hospital, Wilkesbarre, Pa.
- MISS CLARA G. WILLIAMS, Supt., (1909)
Toledo Hospital, Toledo, O.
- CLARENCE W. WILLIAMS, Chr. Hospital Com., (1908)
New England Deaconess' Hospital,
93 Federal St., Boston, Mass.
- MISS ANNIE S. WILLIAMSON, Supt., (1908)
Bay View Hospital, Baltimore, Md.
- MISS MARGARET S. WILSON, Supt., (1905)
Philadelphia Orthopedic Hospital, Philadelphia, Pa.
- ROBERT J. WILSON, M. D., Supt., (1907)
Health Dept. Hospitals, Willard Parker Hospital,
New York City.
- WAYNE McV. WILSON, M. D., Supt., (1909)
New Mexico Cottage Hospital, Silver City, N. Mex.
- SIMON WINDKOS, M. D., Supt., (1909)
Mt. Sinai Hospital, Philadelphia, Pa.
- MISS AGNES M. WOOD, Supt., (1908)
Middlesex County Hospital, Middletown, Conn.

- E. R. WOOD, Chr. Board of Governors, (1908)
Grace Hospital, Toronto, Ont.
- E. A. WOOD, M. D., Supt., (1909)
Maywood Hospital, Sedalia, Mo.
- MISS GRACE F. WOODWARD, Supt., (1908)
Baptist Memorial Hospital, Muskogee, Okla.
- HORACE C. WRINCH, Supt., (1909)
Hazelton Hospital, Hazelton, B. C.
- MISS MARY L. WYCHE, Supt., (1908)
Watts Hospital, Durham, N. C.
- CHAS. H. YOUNG, M. D., Assistant Supt., (1908)
Presbyterian Hospital, New York City. (*Associate*)
- S. J. YOUNG, Trustee, (1908)
Christian Hospital, Valparaiso, Ind.
- THOMAS R. ZULICH, Supt., (1908)
Paterson General Hospital, Paterson, N. J.

MEMBERS

1909-1910

LIST BY STATES

ARIZONA (2)

- MOTHER MARY AGNES, Superior, (1908)
St. Mary's Hospital, Douglas, Ariz.
- HOBART P. SHATTUCK, M. D., Supt., (1909)
Whitwell Hospital, Tucson, Ariz.

CALIFORNIA (17)

- F. K. AINSWORTH, M. D., Exec. Head, (1908)
So. Pacific R. R. Hospitals,
810 James Flood Bldg., San Francisco, Cal.
- L. W. ALLEN, M. D., Supt., (1906)
St. Luke's Hospital, San Francisco, Cal.
- MISS LYDA W. ANDERSON, Supt., (1908)
Pasadena Hospital, Pasadena, Cal.
- H. P. BARTON, M. D., Supt., (1908)
Clara Barton Hospital, Los Angeles, Cal.
- CHAS. C. BROWNING, M. D., Supt., (1907)
Pottenger Sanatorium, Monrovia, Cal.
- MISS FLORA L. DANFORTH, Assistant Supt., (1909)
Los Angeles Hospital, Los Angeles, Cal.
(Associate)
- WM. R. DORR, M. D., Supt., (1909)
City and County Hospital, San Francisco, Cal.
- MARTIN W. FLEMING, Supt., (1908)
Children's Hospital, San Francisco, Cal.
- E. HORSTMANN, M. D., Supt., (1909)
German Hospital, San Francisco, Cal.
- J. L. JONES, M. D., Supt., (1908)
Los Angeles Hospital, Los Angeles, Cal.

- MISS MINNIE LACKENBACH, Assistant Supt., (1909)
Bellevue Hospital, San Francisco, Cal. (*Associate*)
- MISS JENNIE MCKENZIE, Supt., (1909)
California Woman's Hospital, San Francisco, Cal.
- MISS MARION G. PARSONS, Assistant Supt., (1909)
City and County Hospital, San Francisco, Cal.
(*Associate*) •
- MISS CLARA D. PETTITT, Assistant Supt., (1904)
Santa Fe Hospital, Los Angeles, Cal. (*Associate*)
- L. C. SHINGLE, Supt., (1909)
Roosevelt Hospital, Berkeley, Cal.
- MISS V. THERESA SMITH, Supt., (1909)
California Woman's Hospital, San Francisco, Cal.
- MISS LILLIAN L. WHITE, Supt., (1909)
Samuel Merritt Hospital, Oakland, Cal.

CANADA (41)

- B. A. BOAS, 2nd Vice-Pres., (1908)
Western Hospital, Sherbrooke Apmts., Montreal, Que.
- MISS CARRIE M. BOWMAN, Supt., (1907)
Portage La Prairie General Hospital,
Portage La Prairie, Man.
- H. A. BOYCE, M. D., Supt., (1908)
General Hospital, Kingston, Ont. .
- MISS LOUISE C. BRENT, Supt., (1906)
Hospital for Sick Children, Toronto, Ont.
- J. N. E. BROWN, M. D., Supt., (1906)
Toronto General Hospital, Toronto, Ont.
- MISS JANETTE E. CAMERON, Supt., (1907)
Morbon, Cape Breton, N. S.
- MISS ANNIE A. CLEESLEY, Supt., (1908)
St. Luke's General Hospital, Ottawa, Ont.

- M. P. COCHRANE, Trustee, (1908)
Western Hospital, Montreal, Que.
- CHARLES COCKSHUTT, Trustee, (1908)
Toronto General Hospital, Toronto, Ont.
- J. M. COSGRAVE, Supt., (1905)
Winnipeg Hospital, Winnipeg, Man.
- H. C. COX, Trustee, (1908)
Toronto General Hospital, Toronto, Ont.
- W. J. DOBBIE, M. D., Supt., (1908)
King Edward Sanatorium, Weston, Ont.
- MISS BERTHA ELLIOTT, Supt., (1909)
Provincial Hospital, Kentville, N. S.
- J. W. FLAVELLE, Trustee, (1908)
Toronto General Hospital, Toronto, Ont.
- T. H. HEARD, Supt., (1905)
Victoria Hospital, London, Ont.
- W. B. KENDALL, Supt., (1909)
Cottage Hospital, Gravenhurst, Ont.
- WALLACE W. KENNEY, Supt., (1905)
Victoria General Hospital, Halifax, N. S.
- WM. C. T. KERGIN, Supt., (1909)
Port Simpson General Hospital, Port Simpson, B. C.
- MISS SOPHIA McDONALD, Supt., (1909)
Moncton Hospital, Moncton, N. B.
- C. D. MASSEY, Trustee, (1908)
Toronto General Hospital, Toronto, Ont.
- MISS KATE MATHESON, Supt., (1908)
Riverdale Isolation Hospital, Toronto, Ont.
- MISS NELLIE MILLER, Supt., (1907)
Ross Memorial Hospital, Lindsay, Ont.
- MISS MARTHA G. E. MORTON, Supt., (1908)
General and Marine Hospital, Collingwood, Ont.
- MISS GERTRUDE M. MOORE, (1908)
550 Frank St., Ottawa, Ont.

- MISS MARGARET S. PARK, Supt., (1907)
North Bay Hospital, North Bay, Ont.
- J. H. S. PARKE, Supt., (1907)
Montreal General Hospital, Montreal, Que.
- DONALD M. ROBERTSON, M. D., Supt., (1908)
Co. of Carleton General Protestant Hospital,
Ottawa, Ont.
- J. ROSS ROBERTSON, ESQ., Pres. Board of Trustees (1907)
Hospital for Sick Children, Toronto, Ont.
- W. E. ROWLEY, M. D., Supt., (1907)
General Hospital, St. Johns, N. B.
- A. L. RUSSELL, Trustee, (1909)
R. M. and General Hospital, Port Arthur, Ont.
- MISS FRANCES SHARPE, Supt., (1909)
General Hospital, Woodstock, Ont.
- L. J. SHEPPARD, Supt., (1907)
B. & W. Hospital, Berlin, Ont.
- MISS JESSIE M. SHERATON, Supt., (1905)
Aberdeen Hospital, New Glasgow, N. S.
- MISS GERTRUDE SHIELDS, Supt., (1908)
Almonte Victorian Hospital, Almonte, Ont.
- MISS ANNE C. SMITH, Supt., (1908)
Guelph General Hospital, Guelph, Ont.
- D. A. STEWART, Trustee, (1909)
Ninette Sanatorium, Winnipeg, Man.
- MISS H. G. TOLMIE, Supt., (1907)
J. H. Stratford Hospital, Brantford, Ont.
- MISS ANNIE M. TRIPPE, (1908)
Portage La Prairie, Manitoba.
- H. E. WEBSTER, Supt., (1904)
Royal Victoria Hospital, Montreal, Que.
- E. R. WOOD, Chair. Board of Governors, (1908)
Grace Hospital, Toronto, Ont.

HORACE C. WRINCH, Supt., (1909)
Hazelton Hospital, Hazelton, B. C.

COLORADO (7)

W. T. H. BAKER, M. D., Supt., (1905)
Minnequa Hospital, Pueblo, Colo.

JAMES BLACK, Secretary, (1909)
Denver & Rio Grande R. R. Hospital Association.
Denver, Colo. (*Associate*)

M. COLLINS, M. D., Supt., (1903)
National Jewish Hospital, Denver, Colo.

G. W. HOLDEN, M. D., Supt., (1904)
Agnes Memorial Hospital, Denver, Colo.

MOTHER SEBASTIAN SHEA, Supt., (1903)
St. Mary's Hospital, Pueblo, Colo.

MISS MARGARET A. WALLACE, (1909)
424 River St., Canon City, Colo.

MISS ANNIE S. WILLIAMSON, Supt., (1908)
Pueblo Hospital, Pueblo, Colo.

CONNECTICUT (12)

MRS. M. A. ANDREWS, Supt., (1902)
Waterbury Hospital, Waterbury, Conn.

MRS. JENNIE L. BASSETT, Supt., (1906)
New Britain General Hospital, New Britain, Conn.

MRS. S. W. CUTLER, Supt., (1903)
Danbury Hospital, Danbury, Conn.

DAVID RUSSELL LYMAN, M. D., Supt., (1908)
Gaylord Farm Sanatorium, Wallingford, Conn.

F. G. PLATT, Trustee, (1908)
New Britain General Hospital, New Britain, Conn.

CLARENCE E. SKINNER, M. D., Supt., (1909)
Elm City Private Hospital, New Haven, Conn.

- A. W. SMITH, M. D., Supt., (1909)
Hartford Hospital, Hartford, Conn.
- H. T. SUMMERSGILL, M. D., Supt., (1909)
New Haven Hospital, New Haven, Conn.
- FREDERICK SYMINGTON, Supt., (1904)
William W. Backus Hospital, Norwich, Conn.
- MOTHER VALENCIA, Supt., (1908)
St. Francis Hospital, Hartford, Conn.
- MISS R. PHYCHE WEBSTER, Supt., (1908)
Day Kimball Hospital, Putnam, Conn.
- MISS AGNES M. WOOD, Supt., (1908)
Middlesex County Hospital, Middletown, Conn.

CUBA 1)

- MISS M. EUGENIE HIBBARD, Supt., (1908)
Departamento de Beneficencia, Havana, Cuba.

DISTRICT OF COLUMBIA (11)

- MRS. MADGE P. CARTER, Member Hosp. Board (1909)
Jennie Edmundson Memorial Hosp. Council Bluffs, Ia.
Address: The Ventosa, 1st and B Sts., Washington-
ton, D. C. (*Associate*)
- MISS KATHERINE JOHNSON, Assistant Supt., (1909)
Homeopathic Hospital, Washington, D. C. (*Associate*)
- MISS MARIAM LITTLE, Supt., (1907)
National Homeopathic Hospital, Washington, D. C.
- RICHARD R. MACMAHON, Trustee, (1908)
Columbia Hospital, Washington, D. C.
- E. P. MAGRUDER, M. D., Supt., (1909)
Emergency Hospital, Washington, D. C.
- JAS. D. MORGAN, M. D., Trustee, (1909)
Central Dispensary and Emergency Hospital,
Washington, D. C.

- MISS GEORGIA M. NEVINS, Supt., (1909)
Garfield Memorial Hospital, Washington, D. C.
- J. O. SKINNER, M. D., Supt., (1904)
Columbia Hospital, Washington, D. C.
- P. G. SMITH, M. D., Supt., (1909)
Tuberculosis Hospital, Washington, D. C.
- MISS ELIZABETH C. TAYLOR, Assistant Supt., (1909)
Columbia Hospital, Washington, D. C. (*Associate*)
- WM. W. WARFIELD, M. D., Supt., (1909)
Freedmen's Hospital, Washington, D. C.

FLORIDA (4)

- MISS MARY ALBERTA BAKER, Supt., (1908)
St. Luke's Hospital, Jacksonville, Fla.
- MRS. ETHEL P. CLARK, Supt., (1908)
DeSoto Sanatorium, Jacksonville, Fla.
- MISS MARY B. PHELAN, Asst. Supt., (1908)
De Soto Sanatorium, Jacksonville, Fla. (*Associate*)
- WALTER MUCKLOW, Director, (1908)
St. Luke's Hospital, Jacksonville, Fla.

GEORGIA (5)

- THOMAS J. CHARLTON, M. D., Supt., (1908)
Savannah Hospital, Savannah, Ga.
- EUGENE B. ELDER, M. D., Supt., (1905)
The Macon Hospitals, Macon, Ga.
- MRS. MARGARET ELDER, Assistant Supt., (1908)
The Macon Hospitals, Macon, Ga. (*Associate*)
- MISS MARY A. MORAN, Supt., (1908)
Augusta City Hospital, Augusta, Ga.
- WM. B. SUMMERALL, M. D., Supt., (1909)
Grady Hospital, Atlanta, Ga.

HAWAIIAN ISLANDS (1)

- REV. JOHANNES F. ECKARDT, Supt., (1909)
Queen's Hospital, Honolulu, H. I.

ILLINOIS (37)

- MISS MINNIE H. AHRENS, Supt., (1907)
Provident Hospital, Chicago, Ill.
- ASA BACON, Supt., (1906)
Presbyterian Hospital, Chicago, Ill.
- MISS CHRISTINA J. BANKS, (1907)
Wesley Hospital, Chicago, Ill. (*Associate*)
- P. W. BEHRENS, Supt., (1909)
German Hospital, Chicago, Ill.
- MISS SYLVIA BELL, Supt., (1908)
South Chicago Hospital, Chicago, Ill.
- MISS CHRISTINE M. BIGHAM, Supt., (1909)
Ryburn Memorial Hospital, Ottawa, Ill.
- FRANK H. BOOTH, Supt., (1907)
N. W. Side Hospital, Chicago, Ill.
- H. S. BURKHARDT, Pres., (1908)
Central Free Dispensary of W. Chicago,
311 Railway Exchange, Chicago, Ill.
- MISS LUCY CATLIN, (1907)
505 W. State St., Jacksonville, Fla.
- MISS CHARLOTTE CHRISTIAN, Supt., (1910)
Passavant Memorial Hospital, Chicago, Ill.
- MISS FRANCES CRABTREE, (1909)
Anna, Ill.
- LOUIS R. CURTIS, Supt., (1904)
St. Luke's Hospital, Chicago, Ill.
- MISS AMELIA DAHLGREN, Supt., (1907)
Englewood Hospital, Chicago, Ill.

- MISS ANNA LOUISE DAVIS, Supt., (1908)
Evanston Hospital, Evanston, Ill.
- FRANK M. ELLIOTT, Trustee, (1907)
Evanston Hospital Association, Evanston, Ill.
- JOHN A. HORNSBY, M. D., Supt., (1907)
Michael Reese Hospital, Chicago, Ill.
- MISS MARGARET INGLEHART, Trustee, (1908)
Frances E. Willard Hospital, Chicago, Ill.
- MARGARET M. JONES, M. D., Supt., (1909)
Contagious Disease Hospital, Chicago, Ill.
- GEO. B. KELSO, Supt., (1909)
Kelso Sanatorium and Hospital, Bloomington, Ill.
- H. B. KILDAHL, Supt., (1907)
Norwegian Lutheran Hospital, Chicago, Ill.
- MISS ADELAIDE M. LEWIS, Supt., (1907)
Ravenswood Hospital, Chicago, Ill.
- SISTER MARY RAPHEAL MCGILL, Supt., (1907)
Mercy Hospital, Chicago, Ill.
- BERNARD MCHUGH, Sec'y, (1908)
Royal Arcanum Hospital Bed Fund Association,
76 Monroe St., Chicago, Ill. (*Associate*)
- MRS. ERNESTINE PETERSEN, Supt., (1907)
Red Cross Sanatorium, Rock Island, Ill.
- JOS. PURVIS, (1907)
242 S. Kenilworth St., Oak Park, Ill.
- SISTER INGEBOG SPOULAND, Supt., (1907)
Norwegian Lutheran Deaconess' Hospital, Chicago, Ill.
- MISS ELLEN STEWART, Supt., (1907)
Galesburg Hospital, Galesburg, Ill.
- MISS MARY C. STEWART, Supt., (1908)
Marion Sims Hospital, Chicago, Ill.
- WAIT TALCOTT, Sec'y, (1908)
Rockford Hospital Association, Rockford, Ill.

- MISS ALICE I. TWITCHELL, Supt., (1905)
Passavant Hospital, Jacksonville, Ill.
- MRS. RUSSELL TYSON, Supt., (1908)
Children's Memorial Hospital, Chicago, Ill.
- REV. M. WAHLSTROM, Supt., (1906)
Augustana Hospital, Chicago, Ill.
- MISS LUCY WAITE, Supt., (1908)
Mary Thompson Hospital, Chicago, Ill.
- MRS. L. B. WATERS, Supt., (1907)
Passavant Memorial Hospital, Chicago, Ill.
- MISS GRACE G. WATSON, (1908)
Children's Memorial Hospital, Chicago, Ill.
- MISS MARY C. WHEELER, Supt., (1908)
Blessing Hospital, Quincy, Ill.
- J. T. WHITE, M. D., Supt., (1908)
White Sanatorium and National Christian Hospital,
Freeport, Ill.

INDIANA (7)

- MISS M. K. ADAMS, Supt., (1909)
Hope Hospital, Fort Wayne, Ind.
- J. L. FREELAND, M. D., Supt., (1907)
Indianapolis City Hospital, Indianapolis, Ind.
- WM. H. GILBERT, M. D., Supt., (1909)
Mary Jane Gilbert Memorial Hospital, Evansville, Ind.
- WILLARD T. GRAHAM, M. D., Supt., (1909)
Methodist Episcopal Hospital, Indianapolis, Ind.
- E. O. LINDENMUTH, M. D., Supt., (1908)
State College Hospital, Indianapolis, Ind.
- MISS LYDA MCFADDEN, Supt., (1909)
Union Hospital, Terre Haute, Ind.
- S. J. YOUNG, Trustee, (1908)
Christian Hospital, Valparaiso, Ind.

IOWA (6)

MISS GRACE E. BAKER, Supt., (1907)
St. Luke's Hospital, Cedar Rapids, Ia.

MISS AUGUSTA COWPER, Supt., (1907)
St. Luke's Hospital, Davenport, Ia.

MISS ROSE KONOP, (1906)
1710 W. 12th St., Des Moines, Ia.

MISS ESTHER PEARSON, Supt., (1909)
Iowa Methodist Hospital, Des Moines, Ia.

FLORENCE BROWN SHERBON, M. D., Supt., (1909)
Victoria Sanatorium, Colfax, Ia.

J. H. SMITH, Pres., (1908)
St. Luke's Hospital, Cedar Rapids, Ia.

KANSAS (3)

C. C. GODDARD, M. D., Manager, (1909)
Evergreen Place Hospital, Leavenworth, Kan.

MISS PEARL L. LAPTAD, Assistant Supt., (1907)
University of Kansas Hospital, Lawrence, Kan.
(Associate)

MRS. F. G. MCKIBBEN, Supt., (1909)
Keith Hospital, Topeka, Kan.

KENTUCKY (4)

WM. A. GUTHRIE, M. D., Supt., (1909)
Southern Kentucky Hospital, Franklin, Ky.

MISS MARY R. SHAVER, Supt., (1909)
Good Samaritan Hospital, Lexington, Ky.

MISS SOPHIA F. STEINHAEUER, Supt., (1907)
Speers Memorial Hospital, Dayton, Ky.

J. I. WHITTENBERG, M. D., Supt., (1907)
St. John's Eruptive Hospital, Louisville, Ky.

LOUISIANA (1)

GEO. S. BEL, M. D., Trustee, (1909)
Charity Hospital, New Orleans, La.

MAINE (8)

W. E. ELWELL, M. D. Supt., (1905)
National Soldiers' Home, Togus, Me.

MISS RACHEL A. METCALFE, Supt., (1907)
Central Mine General Hospital, Lewiston, Me.

HARRY W. MITCHELL, M. D., Supt., (1909)
Eastern Maine Asylum for the Insane, Bangor, Me.

ESTES NICHOLS, M. D., Supt., (1909)
Maine State Sanatorium, Hebron, Me.

B. D. RIDLON, M. D., Supt., (1908)
National Home for Disabled Volunteer Soldiers,
Togus, Me.

CHAS. D. SMITH, M. D., Supt., (1905)
Maine General Hospital, Portland, Me.

J. FRANK TRULL, M. D., Supt., (1908)
Trull Hospital, Biddeford, Me.

MISS IDA WASHBURN, Supt., (1908)
Eastern Maine Asylum for the Insane, Bangor, Me.

MARYLAND (16)

CHAS. BAGLEY, JR., M. D., Med. Supt., (1909)
The Hebrew Hospital, Baltimore, Md.

EDWARD N. BRUSH, M. D., Supt., (1909)
Sheppard and Enoch Pratt Hospital,
Towson, Station A, Baltimore, Md.

J. CLEMENT CLARK, M. D., Supt., (1909)
Springfield State Hospital, Sykesville, Md.

MISS ANNA E. CHAPMAN, Supt., (1909)
Emergency Hospital, Easton, Md.

- MISS FLORENCE D. ELDRIDGE, Supt., (1908)
Western Maryland Hospital, Cumberland, Md.
- FRANK GAVIN, M. D., Supt., (1904)
Church Home Hospital, Baltimore, Md.
- ANDREW C. GILLIS, M. D., Supt., (1909)
Mercy Hospital, Baltimore, Md.
- A. F. N. HINDLEY, Assistant Supt., (1909)
Eye, Ear and Throat Charity Hospital, Baltimore, Md.
(*Associate*)
- HENRY M. HURD, M. D., Supt., (1904)
Johns Hopkins Hospital, Baltimore, Md.
- MISS M. GRACE MATHEW, Supt., (1909)
Washington County Hospital, Hagerstown, Md.
- J. CARROLL MONMONIER, M. D., Supt., (1908)
Dickeyville and Oella Dispensaries, Dickeyville, Md.
- W. P. MORRILL, M. D., Supt., (1908)
Sydenham Hospital, Baltimore, Md.
- RUPERT NORTON, M. D., Assistant Supt., (1907)
Johns Hopkins Hospital, Baltimore, Md. (*Associate*)
- WALTER B. PLATT, M. D., Supt., (1908)
Robert Garrett Hospital for Children, Baltimore, Md.
- DAVID SCHWAB, Supt., (1908)
The Hebrew Hospital, Baltimore, Md.
- RICHARD J. WHITE, Trustee, (1907)
Johns Hopkins Hospital, Baltimore, Md.

MASSACHUSETTS (54)

- MISS EMMA A. ANDERSON, Supt., (1905)
New England Baptist Hospital, Boston, Mass.
- MISS GRACE B. BEATTIE, Supt., (1905)
Brockton Hospital, Brockton, Mass.
- JAMES LYMAN BELKNAP, M. D., Assistant Supt., (1909)
Mass. General Hospital, Boston, Mass. (*Associate*)

- RICHARD P. BORDEN, Trustee, (1909)
Union Hospital, Fall River, Mass.
- MISS SARA A. BOWEN, Supt., (1905)
Lowell General Hospital, Lowell, Mass.
- G. LORING BRIGGS, Manager, (1909)
Boston Floating Hospital, Boston, Mass.
- L. VERNON BRIGGS, M. D., Supt., (1909)
Broad Oak Farm, Hanover, Mass.
- MISS WINIFRED H. BROOKS, Supt., (1909)
Wesson Maternity Hospital, Springfield, Mass.
- LOUIS H. BURLINGHAM, M. D., Asst. Supt., (1909)
Mass. General Hospital, Boston, Mass. (*Associate*)
- FARRAR COBB, M. D., Supt., (1905)
Charitable Eye and Ear Hospital, Boston, Mass.
- EDMUND D. CODMAN, Trustee, (1909)
Peter Bent Brigham Hospital, Boston, Mass.
- MISS LAURA E. COLEMAN, Supt., (1905)
Faulkner Hospital, Jamaica Plain, Mass.
- MISS LOUISE M. COLEMAN, Supt., (1905)
Hospital of the Good Samaritan, Boston, Mass.
- CHAS. A. DREW, M. D., Supt., (1909)
Worcester City Hospital, Worcester, Mass.
- LUKE W. FARMER, Trustee, (1908)
Somerville Hospital, Somerville, Mass.
- DELLA H. FOLGER, Supt., (1908)
R. S. Frost General Hospital, Chelsea, Mass.
- SISTER GONZAGA, Supt., (1905)
Carney Hospital, South Boston, Mass.
- MRS. E. J. A. HIGGINS, Supt., (1902)
Boston Lying-in Hospital, Boston, Mass.
- MISS ALICE A. GORMAN, Supt., (1908)
Lawrence General Hospital, Lawrence, Mass.
- FREDERICK L. HILLS, M. D., Supt., (1908)
Massachusetts State Sanatorium, Rutland, Mass.

- MISS MAY S. HOLMES, Supt., (1908)
Worcester Isolation Hospital, Worcester, Mass.
- FRANK H. HOLT, M. D., Asst. Supt., (1909)
Boston City Hospital, Boston, Mass. (*Associate*)
- H. B. HOWARD, M. D., Supt., (1901)
Peter Bent Brigham Hospital, Boston, Mass.
- JOS. B. HOWLAND, M. D., Asst. Resident Physician, (1906)
Massachusetts General Hospital, Boston, Mass.
- MISS LUCIA L. JAQUITH, Supt., (1905)
Memorial Hospital, Worcester, Mass.
- JOHN H. MCCOLLOM, M. D., Supt., (1909)
Boston City Hospital, Boston, Mass.
- W. O. MANN, M. D., Supt., (1902)
Massachusetts Homeopathic Hospital, Boston, Mass.
- MISS B. F. MATTICE, Supt., (1905)
Anna Jaques Hospital, Newburyport, Mass.
- PHILLIP C. MEANS, M. D., Assistant Supt., (1907)
Soldiers' Home Hospital, Chelsea, Mass. (*Associate*)
- IRENE W. MORSE, M. D., Supt., (1908)
Clinton Hospital, Clinton, Mass.
- R. W. MORVILLE, JR., Trustee, (1908)
Faulkner Hospital, Jamaica Plain, Boston, Mass.
- MISS MARY K. NELSON, Supt., (1909)
P. E. Truesdale Hospital, Fall River, Mass.
- JOHN H. NICHOLS, M. D., Supt., (1904)
State Hospital, Tewksbury, Mass.
- MISS ELIZABETH B. NIGHTINGLE, Asst. Supt., (1909)
Wesson Maternity Hospital, Springfield, Mass.
(*Associate*)
- MISS ANNA CHANDLER-PARKER, Supt., (1905)
Hale Hospital, Haverhill, Mass.
- MISS GRACE G. PILLSBURY, Supt., (1905)
Addison Gilbert Hospital, Gloucester, Mass.

- MISS MARY H. RIDDLE, Supt., (1905)
Newton Hospital, Newton, Mass.
- SISTER M. ROSE, Supt., (1908)
St. Elizabeth's Hospital, Boston, Mass.
- MRS. MARY ELY ROTHROCK, Supt., (1909)
Union Hospital, Fall River, Mass.
- GEO. H. M. ROWE, M. D., (1901)
Boston City Hospital, Boston, Mass.
- MISS HANNAH F. SEARCY, Supt., (1905)
Milford Hospital, Milford, Mass.
- C. C. SHELDON, M. D., Supt., (1904)
Lynn Hospital, Lynn, Mass.
- CHAS. E. SIMPSON, M. D., Supt., (1904)
Lowell Hospital, Lowell, Mass.
- MISS EMMA M. SMITH, Supt., (1909)
Jordan Hospital, Plymouth, Mass.
- A. A. STARBUCK, M. D., Supt., (1909)
Wesson Memorial Hospital, Springfield, Mass.
- MISS WINIFRED L. STEVENS, Supt., (1909)
The Clinton Hospital, Clinton, Mass.
- EDWARD F. STEVENS, Member Hosp. Com., (1909)
N. E. Deaconess' Hospital, Boston, Mass. (*Associate*)
- MISS MARJORIE M. TAYLOR, M. D., Supt., (1908)
42 Brownfield Rd., West Summerfield, Mass.
- STELLA M. TAYLOR, M. D., Supt., (1903)
New England Hospital for Women, Boston, Mass.
- CHAS. E. THOMPSON, M. D., Supt., (1909)
State Colony for the Insane, Gardner, Mass.
- PHILEMON E. TRUESDALE, M. D., Trustee, (1909)
P. E. Truesdale Hospital, Fall River, Mass.
- GEO. T. TUTTLE, Supt., (1909)
McLean Hospital, Waverly, Mass.

- F. A. WASHBURN, M. D., Supt., (1904)
Massachusetts General Hospital, Boston, Mass.
- CLARENCE W. WILLIAMS, Chr. Hospital Committee, (1908)
New England Deaconess' Hospital, Boston, Mass.

MICHIGAN (26)

- MISS CHARLOTTE A. AIKENS, (1906)
722 Sheridan Ave., Detroit, Mich.
- W. L. BABCOCK, M. D., Supt., (1906)
The Grace Hospital, Detroit, Mich.
- MISS IDA M. BARRETT, Supt., (1903)
Union Benevolent Assn. Hospital, Grand Rapids, Mich.
- JOHN W. BLODGETT, Trustee, (1907)
Union Benevolent Assn. Hospital, Grand Rapids, Mich.
- C. B. BURR, M. D., Supt., (1909)
Oak Grove Sanatorium, Flint, Mich.
- ALICE M. DEFORD, M. D., (1909)
Detroit, Mich.
- JAMES A. DEVORE, M. D., Supt., (1907)
DeVore Hospital and Sanatorium, Grand Rapids, Mich.
- J. B. DRAPER, Supt., (1908)
University Hospital, Ann Arbor, Mich.
- MISS ELIZABETH G. FLAWS, Supt., (1908)
Butterworth Hospital, Grand Rapids, Mich.
- ELISHA H. FLINN, Trustee, (1908)
The Grace Hospital, Detroit, Mich.
- MISS ELIZABETH A. GREENER, Supt., (1908)
Hackley Hospital, Muskegon, Mich.
- MISS WILHELMINA HAMILTON, Assistant Supt., (1909)
Jackson City Hospital, Jackson, Mich. (*Associate*)
- J. F. HARTZ, (1909)
Detroit, Mich. (*Associate*)

- MRS. MAUDE HORNER, Supt., (1909)
Woman's Hospital, Detroit, Mich.
- J. L. HUDSON, Trustee, (1908)
Harper Hospital, Detroit, Mich.
- J. H. KELLOGG, M. D., Supt., (1910)
Battle Creek Sanatorium, Battle Creek, Mich.
- MISS ELIZABETH McCLASKIE, Supt., (1908)
General Hospital, Port Huron, Mich.
- THEODORE R. McCLURE, M. D., Supt., (1907)
Solvay General Hospital, Detroit, Mich.
- WALTER P. MANTON, M. D., Pres., (1908)
Woman's Hospital, Detroit, Mich.
- MISS MARGARET M. MOORE, Supt., (1908)
Jackson City Hospital, Jackson, Mich.
- F. E. MOULDER, Supt., (1907)
Harper Hospital, Detroit, Mich.
- ALFRED I. NOBLE, M. D., Supt., (1907)
Hospital for Insane, Kalamazoo, Mich.
- REED PARKHURST, Assistant Supt., (1908)
Muskegon County Hospital, Muskegon, Mich.
(Associate)
- MISS IDA E. PROCTOR, Supt., (1908)
General Hospital, Saginaw, Mich.
- A. B. SIMONSON, M. D., Supt., (1909)
Calumet & Hecla Hospital, Calumet, Mich.
- MISS C. P. VAN DER WATER (1907)
The Grace Hospital, Detroit, Mich. (Associate)

MINNESOTA (18)

- A. B. ANCKER, M. D., Supt., (1902)
City and County Hospital, St. Paul, Minn.
- RICHARD O. BEARD, M. D., Sec'y, (1909)
University of Minnesota Hospitals, Minneapolis, Minn.

- MISS ELSIE A. BRUNTLETT, Supt., (1908)
Stillwater City Hospital, Stillwater, Minn.
- HERBERT O. COLLINS, M. D., Supt., (1909)
City Hospital, Minneapolis, Minn.
- DANIEL C. DARROW, M. D., Supt., (1909)
Darrow Hospital, Moorhead, Minn.
- MISS HARRIET HARTY, Supt., (1907)
St. Barnabas Hospital, Minneapolis, Minn.
- PETER M. HALL, M. D., (1908)
Minneapolis, Minn.
- MISS SUSAN HOLMES, Supt., (1908)
Dr. Abbott's Hospital, Minneapolis, Minn.
- IRVING P. JOHNSON, Trustee, (1909)
St. Barnabas Hospital, Minneapolis, Minn.
- W. A. JONES, M. D., Chr. Exec. Com. (1908)
University Hospitals, Minneapolis, Minn.
- MISS LYDA H. KELLER, Supt., (1907)
Cobb Hospital, St. Paul, Minn.
- MRS. SARAH KNIGHT, Supt., (1909)
Asbury M. E. Deaconess' Hospital and Home,
Minneapolis, Minn.
- MISS DELIA O'CONNELL, Supt., (1908)
Rest Hospital, Minneapolis, Minn.
- MISS S. C. PALMER, Assistant Supt., (1909)
Asbury M. E. Deaconess' Hospital and Home,
Minneapolis, Minn. (*Associate*)
- MISS ADAH H. PATTERSON, Supt., (1908)
St. Luke's Hospital, St. Paul, Minn.
- MISS ELIZABETH PETERSON, Supt., (1908)
Swedish Hospital, Minneapolis, Minn.
- R. M. PHELPS, M. D., Assistant Supt., (1908)
Rochester State Hospital, Rochester, Minn. (*Associate*)
- MISS ELEANOR WESTON, Supt., (1904)
Northwestern Hospital, Minneapolis, Minn.

MISSISSIPPI (2)

- MISS SADIE HOWARD, Supt.,
Vicksburg Hospital, Vicksburg, Miss.
- MISS CATHERINE E. MORAN, Supt., (1908)
So. Mississippi Infirmary, Hattiesburg, Miss.

MISSOURI (16)

- J. H. CADWALLADER, M. D., Supt., (1908)
Missouri Baptist Sanatorium, St. Louis, Mo.
- MISS ANNIE M. CASEY, Supt., (1907)
German Hospital, Kansas City, Mo.
- MRS. MARY J. CHAMBERS, Supt., (1908)
St. Luke's Hospital, St. Louis, Mo.
- O. H. ELBRECHT, M. D., Supt., (1905)
Female Hospital, St. Louis, Mo.
- MISS CHARLOTTE FORESTER, Supt., (1909)
University Hospital, Kansas City, Mo.
- MISS ELEANOR KELLY, Supt., (1909)
St. Luke's Hospital, Kansas City, Mo.
- WALTER C. G. KIRCHNER, M. D., Supt., (1907)
City Hospital, St. Louis, Mo.
- MISS MAUDE LANDIS, Supt., (1909)
Levering Hospital, Hannibal, Mo.
- MISS HARRIETT LECK, Assistant Supt., (1909)
New General Hospital, Kansas City, Mo. (*Associate*)
- MISS VIRGINIA PORTER, Supt., (1909)
Mercy Hospital, Kansas City, Mo.
- G. WILSE ROBINSON, M. D., Supt., (1909)
Kansas City General Hospital, Kansas City, Mo.
- MISS MARGARET ROGERS, Supt., (1909)
The Jewish Hospital, St. Louis, Mo.
- E. W. SAUNDERS, M. D., Supt., (1903)
Bethesda Hospital, St. Louis, Mo.

- WAYNE SMITH, M. D., Supt., (1908)
Wash. University Hosp. and Dispensary, St. Louis, Mo.
- JOS. V. STRAUB, Trustee, (1908)
German Hospital, Kansas City, Mo.
- E. A. WOOD, M. D., Supt., (1909)
Maywood Hospital, Sedalia, Mo.

NEBRASKA (4)

- BENJ. F. BAILEY, M. D., Med. Supt., (1909)
Benj. F. Bailey Sanatorium, Lincoln, Neb.
- M. W. BAXTER, M. D., Supt., (1909)
Nebraska State Hospital, Ingleside, Neb.
- W. K. LOUGHRIDGE, M. D., Supt., (1909)
Dr. Loughridge's Private Hospital, Milford, Neb.
- J. P. PERCIVAL, M. D., Supt., (1909)
Norfolk Hospital for the Insane, Norfolk, Neb.

NEW HAMPSHIRE (6)

- MISS GRACE P. HASKELL, Supt., (1909)
Wentworth Hospital, Dover, N. H.
- MISS ELIZABETH E. HEINEMAN, Supt., (1908)
Nashua Emergency Hospital, Nashua, N. H.
- MISS ANNA C. LOCKERBY, Assistant Supt., (1907)
Mary Hitchcock Memorial Hospital, Hanover, N. H.
(Associate)
- MISS IDA A. NUTTER, Supt., (1908)
Franklin Hospital, Franklin, N. H.
- MISS AUGUSTA C. ROBERTSON, Supt., (1905)
Elliott Hospital, Manchester, N. H.
- MISS IDA F. SHEPARD, Supt., (1905)
Mary Hitchcock Hospital, Hanover, N. H.

NEW JERSEY (14)

- GEO. BAILEY, JR., Supt., (1901)
Cooper Hospital, Camden, N. J.
- MISS EDNA L. CHAMBERS, Supt., (1908)
Christ Hospital, Jersey City, N. J.
- HENRY A. COTTON, M. D., Supt., (1909)
New Jersey State Hospital, Trenton, N. J.
- G. K. DICKINSON, M. D., Trustee, (1908)
Christ Hospital, Jersey City, N. J.
- ISAAC W. ENGLAND, Trustee, (1908)
Passaic General Hospital, Passaic, N. J.
- MISS IRENE FALLON, (1904)
Milburn, N. J.
- ELLIOTT M. HENDERSON, Trustee, (1908)
Passaic General Hospital, Passaic, N. J.
- MISS LAURA B. ILICK, Supt., (1909)
Orange Memorial Hospital, Orange, N. J.
- MISS WILHELMINA KOBBELIER, Supt., (1908)
German Hospital, Newark, N. J.
- MORTIMER LAMPSON, M. D., Supt., (1908)
Jersey City Hospital, Jersey City, N. J.
- WILLIAM L. LYALL, Trustee, (1908)
Passaic General Hospital, Passaic, N. J.
- CHAS. E. TALBOT, Supt., (1904)
Newark City Hospital, Newark, N. J.
- MISS MARGARET A. WALLACE, Supt., (1909)
General Hospital, Passaic, N. J.
- THOMAS R. ZULICH, Supt., (1908)
Paterson General Hospital, Paterson, N. J.

NEW MEXICO (3)

- F. C. DIVER, M. D., (1909)
Dawson Hospital, Dawson, New Mex.

- H. M. SMITH, M. D., Supt., (1909)
N. M. A. I. Hospital, East Las Vegas, New Mex.
- WAYNE McV. WILSON, M. D., Supt., (1909)
New Mexico Cottage Hospital, Silver City, New Mex.

NEW SOUTH WALES (1)

- WILLIAM EPPS, Secretary to Hospital, (1907)
Royal Prince Alfred Hospital,
Sydney, New South Wales.

NEW YORK (125)

- LEO ARNSTEIN, Trustee, (1908)
Mt. Sinai Hospital, New York City; 49 East 82d St.
- S. T. ARMSTRONG, M. D., (1905)
Katonah, N. Y.
- WILLIAM SEAMAN BAINBRIDGE, M. D., Trustee, (1908)
N. Y. Skin and Cancer Hospital,
34 Gramercy Park, New York City.
- O. H. BARTINE, Supt., (1907)
Hospital for Ruptured and Crippled, New York City.
- MISS NELLIE J. BENTON, Supt., (1909)
Buffalo Homeopathic Hospital, Buffalo, N. Y.
- CLEMENT A. BERARD, Supt., (1909)
French Benevolent Society, New York City.
- MISS FRANCES H. BESCHERER, Head Nurse, (1909)
Albany Guild for the Care of the Sick, Albany, N. Y.
- MISS R. ELIZABETH BISMED, Supt., (1909)
St. John's Riverside Hospital, Yonkers, N. Y.
- D. M. BLOOM, M. D., Assistant Supt., (1908)
Mt. Sinai Hospital, New York City. (*Associate*)
- MISS MARY W. BOOTH, Pres. Board of Trustees (1908)
Lincoln Hospital, New York City.
Address: Englewood, N. J.

- HENRY J. BOSTWICK, Assistant Supt., (1907)
Clifton Springs Sanatorium, Clifton Springs, N. Y.
(Associate)
- JOHN W. BRANNAN, M. D., Pres. Board of Trustees, (1908)
Bellevue and Allied Hospitals,
11 West 12th St., New York City.
- W. P. BROWN, Governor, (1908)
New York Hospital, 59 Wall St., New York City.
- H. G. BUGBEE, M. D., Supt., (1908)
Vassar Brothers' Hospital, Poughkeepsie, N. Y.
- MISS SARAH BURNS, Supt., (1908)
New York Skin and Cancer Hospital, New York City.
- FREDERICK BRUSH, M. D., Supt., (1909)
Post Graduate Hospital, New York City.
- BAILEY B. BURRITT, Asst. Secy., (1909)
State Charities Aid Association, New York City.
(Associate)
- MISS NANCY E. CADMUS, Supt., (1905)
Manhattan Maternity and Dispensary, New York City.
- ALEXANDER H. CANDLISH, Supt., (1908)
New York Eye and Ear Infirmary, New York City.
- J. G. CANNON, Trustee, (1909)
Hahnemann Hospital, New York City.
- M. CAVANA, M. D., Supt., (1909)
Oneida Private Hospital, Sylvan Beach, N. Y.
- REV. GEO. F. CLOVER, Supt., (1907)
St. Luke's Hospital, New York City.
- W. B. COGSWELL, Pres. Board of Trustees, (1908)
Hospital of the Good Shepherd, Syracuse, N. Y.
- WM. H. CONDON, Supt., (1909)
German Hospital, Brooklyn, N. Y.
- MISS E. P. CRANDALL,
265 Henry St., New York City.
- HENRY G. DANFORTH, Trustee, (1909)
Rochester City Hospital, Rochester, N. Y.

- WILLIAM DAUB, Supt., (1908)
Lebanon Hospital, New York City.
- MISS IDA E. DAVIS, Ass't Supt., (1909)
St. John's Riverside Hospital,
Yonkers, N. Y. (*Associate*.)
- MISS VERA D. EATON, Supt., (1908)
Lockport City Hospital, Lockport, N. Y.
- IGON EGGHARD, Supt., (1907)
Sydenham Hospital, New York City.
- MISS NANCY P. ELLICOTT, Supt., (1909)
Rockefeller Institute Hospital, New York City.
- CHAS. P. EMERSON, M. D., Supt., (1908)
Clifton Springs Sanatorium, Clifton Springs, N. Y.
- MISS ARVILLA E. EVERINGHAM, Supt., (1908)
Onondaga County Hospital, Onondaga, N. Y.
- C. IRVING FISHER, M. D., Supt., (1901)
Presbyterian Hospital, New York City.
- J. F. FITZGERALD, M. D., Supt., (1905)
Kings County Hospital, Brooklyn, N. Y.
- MISS FRANCES E. FOWLER, Supt., (1903)
Women's Hospital, New York City.
- LOUIS J. FRANK, Supt., (1907)
Beth Israel Hospital, New York City.
- MISS GRACE H. FRANKLIN, Supt., (1905)
N. Y. Medical College and Hospital, New York City.
- MISS SARA A. GAINSFORTH, Supt., (1908)
Harlem Hospital, New York City.
- MISS HELEN M. GARRETT, Supt., (1905)
City Hospital, Amsterdam, N. Y.
- MRS. GERTRUDE GIBSON, Supt., (1903)
Prospect Heights Hospital, Brooklyn, N. Y.
- MISS MARY E. GLADWIN, Asst. Supt., (1905)
Woman's Hospital, New York City. (*Associate*)
- S. S. GOLDWATER, M. D., Supt., (1904)
Mt. Sinai Hospital, New York City.

- MISS MARY M. GOODRICH, Asst. Supt., (1905)
New York Infirmary for Women and Children,
New York City. (*Associate.*)
- HAROLD C. GOODWIN, M. D., Supt., (1908)
Albany Hospital, Albany, N. Y.
- LEWIS T. GRIFFITH, M. D., Supt., (1909)
New York Red Cross Hospital, New York City.
- CHAS. B. GRIMSHAW, Supt., (1907)
Roosevelt Hospital, New York City.
- JOHN GUNN, Supt., (1906)
Polyclinic Hospital, New York City.
- MORRIS HARRISON, Supt., (1909)
Williamsburgh Hospital, Brooklyn, N. Y.
- HENRY B. HATHAWAY, Trustee, (1907)
Rochester Homeopathic Hospital, Rochester, N. Y.
- ADOLPH HAUSMAN, Supt., (1908)
Montefiore Home and Hospital, New York City.
- MISS ELIZABETH HAYDEN, Supt., (1908)
Red Cross Hospital, New York City.
- MISS S. HENRY, Supt., (1908)
Newburgh Hospital, Newburgh, N. Y.
- MILTON P. HERRMAN, Trustee, (1909)
Mt. Sinai Hospital, New York City.
- MISS HELEN G. HILL, Supt., (1909)
Children's Hospital, Buffalo, N. Y.
- PAUL HIRSCH, Trustee, (1907)
Lebanon Hospital, 19 Whitehall St., New York City.
- W. W. HOPPIN, Gov., (1908)
New York Hospital, 52 William St., New York City.
- E. H. HOWARD, M. D., Supt., (1909)
Rochester State Hospital, Rochester, N. Y.
- DR. THOS. HOWELL, Supt., (1902)
New York Hospital, New York City.

- MRS. HELEN S. HOWES, Supt., (1904)
Dobbs Ferry Hospital, Dobbs Ferry, N. Y.
- MISS DOROTHY M. HUGO, Assistant Supt., (1908)
Amsterdam City Hospital, Amsterdam, N. Y.
(Associate.)
- ARTHUR W. HURD, M. D., Supt., (1905)
Buffalo State Hospital, Buffalo, N. Y.
- MISS IRENE M. JOHNSON, Supt., (1909)
Memorial Hospital, Niagara Falls, N. Y.
- MISS MAUDE L. JOHNSTON, Supt., (1907)
Rochester Homeopathic Hospital, Rochester, N. Y.
- ISRAEL C. JONES, M. D., Supt., (1904)
Home for Incurables, Fordham, N. Y.
- REV. A. S. KAVANAGH, Supt., (1906)
Methodist Episcopal Hospital, Brooklyn, N. Y.
- MRS. J. A. KEHLBECK, Trustee, (1908)
The Jamaica Hospital, 2195 Broadway, New York City.
- MISS MARY L. KEITH, Supt., (1905)
Rochester City Hospital, Rochester, N. Y.
- LOUIS KORTUM, Supt., (1907)
German Hospital and Dispensary, New York City.
- MISS ELIN K. KRAEMER, Supt., (1908)
Fred. Ferris Thompson Hospital, Canandaigua, N. Y.
- ADOLF KUTTROFF, Trustee, (1908)
German Hospital and Dispensary,
128 Duane St., New York City.
- AMZI LAKE, (1906)
New York City.
- MRS. A. M. LAWSON, Supt., (1902)
General Memorial Hospital, New York City.
- MISS LINA LIGHTBOURN, Supt., (1906)
Hospital of the Good Shepherd, Syracuse, N. Y.

- MISS JULIA A. LITTLEFIELD, Supt., (1909)
Schenectady Physicians' Hospital,
Schenectady, N. Y.
- GEO. P. LUDLAM, Emeritus Supt., (1902)
New York Hospital, New York City.
- MISS FRANCES L. LURKINS, Supt., (1902)
Laura Franklin Hospital for Children, New York City.
- H. E. MONTGOMERY, Trustee, (1908)
Buffalo Homeopathic Hospital,
Court and Wilkinson Sts., Buffalo, N. Y.
- MISS MARGARET MUNN, Supt., (1908)
N. Y. Infirmary for Women and Children,
New York City.
- JAMES U. NORRIS, Supt., (1908)
Rockefeller Institute for Medical Research. New York
New York City.
- EX. NORTON, Trustee, (1909)
S. R. Smith Infirmary, Staten Island, N. Y.
- HENRY F. NOYES, Pres. Board of Trustees, (1907)
Brooklyn Hospital, Brooklyn, N. Y.
- MISS IDA NUDELL, Supt., (1908)
White Plains Hospital, White Plains, N. Y.
- REUBEN O'BRIEN, Supt., (1901)
Manhattan Eye and Ear Hospital, New York City.
- MISS MARY W. OSBORN, Supt., (1907)
Brooklyn Hospital, Brooklyn, N. Y.
- W. S. OVERTON, M. D., Supt., (1909)
Moore-Overton Hospital, Binghamton, N. Y.
- CELESTINO PIVA, Pres., (1908)
Italian Benevolent Institute and Hospital,
167 West Houston St., New York City.
- GEO. M. PRICE, Trustee, (1908)
Hospital of the Good Shepherd, Syracuse, N. Y.
- W. J. RICKARD, Assistant Supt., (1907)
Bellevue Hospital, New York City. (*Associate.*)

- BERNARD RIPPIN, Assistant Supt., (1909)
Sydenham Hospital, New York City. (*Associate.*)
- GEO. L. RIVES, Trustee, (1909)
New York Hospital, New York City.
- THOMAS K. ROBERTSON, Assistant Supt., (1907)
New York Hospital, New York, N. Y. (*Associate.*)
- RENWICK R. ROSS, M. D., Supt., (1904)
Buffalo General Hospital, Buffalo, N. Y.
- SISTER ST. JAMES, Superior, (1908)
City Hospital, Ogdensburg, N. Y.
- GEO. F. SAUER, Supt., (1909)
Home of Rest for Consumptives,
Bolton Road, New York.
- MISS ANNA L. SCHULZE, Supt., (1908)
Saratoga Hospital, Saratoga Springs, N. Y.
- MISS MARY E. SCHUMACKER, Supt., (1906)
Sanatorium Hospital, Troy, N. Y.
- NEWTON M. SHAFFER, M. D., Supt., (1909)
N. Y. State Hospital for the Care of
Crippled and Deformed Children, New York City.
- RICHARD E. SHAW, M. D., Supt., (1901)
Long Island College Hospital, Brooklyn, N. Y.
- MISS LAURA A. SLEE, Supt., (1900)
Women's and Children's Hospital, Syracuse, N. Y.
- J. WILLIAM SMITH, Trustee, (1908)
Hospital of the Good Shepherd, Syracuse, N. Y.
- MISS MARY AGNES SMITH, Supt., (1908)
Babies' Hospital, New York City.
- WINFORD H. SMITH, M. D., Supt., (1906)
Bellevue Hospital, New York City.
- W. H. SPILLER, M. D., Supt., (1908)
New York Lying-in Hospital, New York City.

- J. EDWARD STOHLMANN, M. D., Supt., (1906)
New York Infant Asylum, New York City.
- CHAS. STOVER, M. D., Trustee, (1909)
Amsterdam City Hospital, Amsterdam, N. Y.
- C. EUGENE STRASSER, Supt., (1907)
Jewish Hospital, Brooklyn, N. Y.
- REV. PAUL F. SWETT, Supt., (1909)
St. Johns Hospital, Brooklyn, N. Y.
- MISS MARY J. TAYLOR, Supt., (1908)
Homeopathic Hospital, Albany, N. Y.
- MISS MARY M. THOMPSON, Assistant Supt., (1909)
F. F. Thompson Memorial Hospital,
Canandaigua, N. Y. (*Associate*.)
- GEO. TIMMINS, Trustee, (1908)
Hospital of the Good Shepherd, Syracuse, N. Y.
- J. G. TIMOLAT, Trustee, (1909)
S. R. Smith Infirmary, Staten Island, N. Y.
- RICHARD H. TOWNLEY, Supt., (1904)
Lincoln Memorial Hospital, New York City.
- HOWARD TOWNSEND, Trustee, (1908)
New York Hospital, 32 Nassau St., New York City.
- FRANK VAN KLECK, Trustee, (1908)
Vassar Brothers' Hospital, Poughkeepsie, N. Y.
- SIEGFRIED WACHSMANN, M. D., Medical Director, (1909)
Montefiore Home, New York City.
- JOHN B. WALKER, M. D., Managing Director, (1908)
New York City Private Hospital Association,
33 East 33rd St., New York City.
- MRS. ELDORA H. WARD, Supt., (1904)
Jamaica Hospital, Jamaica, N. Y.
- A. W. WEISMANN, Supt., (1907)
Hahnemann Hospital, New York City.

- A. W. WELLINGTON, Trustee, (1908)
J. Hood Wright Memorial Hospital,
301 West 106th St., New York City.
- MISS FLORENCE L. WETMORE, Supt., (1908)
Flushing Hospital, Flushing, N. Y.
- JULIUS M. WILE, Trustee, (1909)
Rochester City Hospital, Rochester, N. Y.
- WILLIAM G. WILLCOX, Trustee, (1909)
S. R. Smith Infirmary, Tompkinsville, N. Y.
- ROBERT J. WILSON, Supt., (1907)
Health Dept. Hospitals, Willard Park Hospital,
New York City.
- CHAS. H. YOUNG, M. D., Assistant Supt., (1908)
Presbyterian Hospital, New York City. (*Associate.*)

NORTH CAROLINA (9)

- MISS EMILY L. BIZLEY, Supt., (1908)
Asheville Mission Hospital, Asheville, N. C.
- ROBERT S. CARROLL, M. D., Supt., (1910)
Dr. Carroll's Sanatorium, Asheville, N. C.
- MISS CATHERINE P. HAYDEN, Assistant Supt., (1908)
St. Agnes Hospital, Raleigh, N. C. (*Associate.*)
- J. F. HIGHSMITH, M. D., Supt., (1908)
Highsmith Hospital, Fayetteville, N. C.
- H. P. McKNIGHT, M. D., Supt., (1909)
Camp Health Sanatorium, Southern Pines, N. C.
- PAUL PAQUIN, M. D., Supt., (1909)
Asheville-Biltmore Sanatorium, Asheville, N. C.
- RALPH B. SEEM, M. D., Supt., (1909)
James Walker Memorial Hospital, Wilmington, N. C.
- MISS M. T. SHACKLEFORD, Supt., (1908)
Pittman Hospital, Tarboro, N. C.

MISS MARY L. WYCHE, Supt., (1908)
Watts Hospital, Durham, N. C.

NORTH DAKOTA (1)

MISS LOUISE HOERMAN, Assistant Supt., (1909)
Bismarck Hospital and Deaconess' Home,
Bismarck, N. D. (*Associate.*)

OHIO (15)

JOHN FEHRENBATCH, Supt., (1901)
Cincinnati Hospital, Cincinnati, O.

MISS SOPHIA M. FOLSOM, Supt., (1908)
Mt. Sinai Hospital, Cleveland, O.

MISS LOUISE GOLDER, Supt., (1908)
Bethesda Hospital, Cincinnati, O.

MISS ALMA C. HOGLE, Supt., (1905)
Cleveland Homeopathic Hospital, Cleveland, O.

MISS MAE N. KRS, (1908)
22 Euclid Heights, Cleveland, O.

MISS MARIE A. LAWSON, Supt., (1903)
City Hospital, Akron, O.

MISS MATILDA J. LINSKEY, Supt., (1908)
Emergency Hospital, Mansfield, O.

MISS KATHERINE McCONNELL, Supt., (1907)
Ashtabula General Hospital, Ashtabula, O.

HERMAN PRETZINGER, Trustee, (1908)
Miami Valley Hospital, Dayton, O.

A. J. RANNEY, M. D., Supt., (1905)
Lakeside Hospital, Cleveland, O.

J. M. RATLIFF, M. D., Supt., (1909)
Dayton Sanatorium, Dayton, O.

MISS S. A. SIMS, Supt., (1904)
Youngstown Hospital, Youngstown, O.

JOHN M. SMITH, Supt., (1908)
Grant Hospital, Columbus, O.

W. H. WEBBER, (1899)
2401 Cedar St., Cleveland, O.

MISS CLARA G. WILLIAMS, Supt., (1909)
Toledo Hospital, Toledo, O.

OKLAHOMA (5)

F. H. CLARK, M. D., Supt., (1909)
El Reno Sanatorium, El Reno, Okla.

ROBERT H. HENRY, Supt., (1909)
Ardmore Sanatorium, Ardmore, Okla.

MISS STELLA SHIPLEY, Supt., (1909)
Bartlesville Hospital, Bartlesville, Okla.

MISS JEWEL V. STAFFORD, Supt., (1909)
Muskogee Hospital, Muskogee, Okla.

MISS GRACE F. WOODWARD, Supt., (1908)
Baptist Memorial Hospital, Muskogee, Okla.

OREGON (1)

HOWARD L. DUMBLE, M. D., Supt., (1909)
The Cottage Hospital, Hood River, Ore.

PENNSYLVANIA (51)

MISS ELIZABETH W. ANCKER, Supt., (1908)
Western Phila. Hosp. for Women, Philadelphia, Pa.

MISS MAUD BANFIELD, Supt., (1900)
Polyclinic Hospital, Philadelphia, Pa.

- P. K. BECHTEL, Supt., (1902)
Allegheny General Hospital, Allegheny, Pa.
- JAMES H. BIGGER, Supt., (1907)
Western Pennsylvania Hospital, Pittsburg, Pa.
- MARY BRANSON, M. D., Pres. Board of Trustees, (1908)
Women's Southern Homeopathic Hospital,
1504 Locust St., Philadelphia, Pa.
- J. R. CODDINGTON, Supt., (1900)
Samaritan & Garretson Hospitals, Philadelphia, Pa.
- MISS MARGARET M. CUMMINGS, Supt., (1909)
Pittston Hospital, Pittston, Pa.
- MISS CONSTANCE V. CURTIS, Supt., (1904)
Phoenixville Hospital, Phoenixville, Pa.
- DAVID N. DENNIS, M. D., Pres. Hospital Com., (1908)
Hamot Hospital, Erie, Pa.
- FRANCIS A. DEVLIN, Supt., (1908)
Municipal Hospital, Pittsburg, Pa.
- MISS JESSIE M. DURSTINE, Supt., (1909)
Clearfield Hospital, Clearfield, Pa.
- MISS MARY ECHELBERGER, Asst. Supt., (1908)
Polk Hospital, Polk, Pa. (*Associate.*)
- MISS IDA R. FALCONER, Supt., (1908)
Corry Hospital, Corry, Pa.
- MISS BLANCHE K. FLEMING, Supt., (1908)
Beaver Co. General Hospital, Rochester, Pa.
- SISTER M. FRANCIS, Supt., (1908)
Pittsburg Hospital, Pittsburg, Pa.
- MISS M. N. GABLE, Supt., (1909)
Chambersburg Hospital, Chambersburg, Pa.
- MISS ANNA C. GARRETT, Supt., (1908)
Frankford Hospital, Frankford, Phila., Pa.
- MISS L. A. GIBERSON, Supt., (1909)
American Oncologic Hospital, Philadelphia, Pa.

- CHAS. A. GILL, Supt., (1904)
Germantown Hospital, Germantown, Pa.
- MISS JANET GORDON GRANT, Supt., (1908)
Moses Taylor Hospital, Scranton, Pa.
- MISS JESSIE L. GREENE, Supt., (1909)
Conemaugh Valley Hospital, Johnstown, Pa.
- MISS CLARA V. HARING, Supt., (1908)
Allentown Hospital, Allentown, Pa.
- ROBERT E. HASTINGS, Trustee, (1909)
University of Pennsylvania Hospital, Philadelphia, Pa.
- MARY J. HAYS, M. D., Supt., (1908)
Kane Summit Hospital, Kane, Pa.
- MISS MAY Y. HILL, Supt., (1908)
West Side Hospital, Scranton, Pa.
- MISS HELEN HINDMAN, Supt., (1910)
Donaldson Hospital, Williamsport, Pa.
- MISS ELLEN M. HUNT, Supt., (1909)
Cottage State Hospital, Mercer, Pa.
- WALTER LATHROP, M. D., Supt., (1901)
State Hospital, Hazelton, Pa.
- J. H. McCLELLAND, M. D., Trustee, (1908)
Homeopathic Hospital, Pittsburg, Pa.
- JAMES E. MATTHEWS, Supt., (1907)
State Hospital, Scranton, Pa.
- S. G. MORBON MAULE, Trustee, (1909)
Hahnemann Medical College and Hospital,
Philadelphia, Pa.
- MISS KATHERINE A. MOYER, Supt., (1909)
Pottstown Hospital, Pottstown, Pa.
- MISS ANNIE C. NEDWILL, Supt., (1908)
St. Timothy's Hospital, Roxborough, Phila., Pa.
- MISS JEANNE NEWINGTON, Supt., (1909)
Homestead Hospital, Homestead, Pa.

- H. L. ORTH, M. D., Supt., (1909)
Pennsylvania State Lunatic Hospital, Harrisburg, Pa.
- MISS ANNA M. RINDLAUB, Supt., (1909)
South Side Hospital, Pittsburg, Pa.
- ALICE M. SEABROOK, M. D., Supt., (1902)
Women's Hospital, Philadelphia, Pa.
- MISS MARY E. SMITH, Supt., (1907)
Columbia Hospital, Pittsburg, Pa.
- MISS CLARA F. SOLLENBERGER, Supt., (1909)
Coatesville Hospital, Coatesville, Pa.
- JAMES F. SPEER, Supt., (1909)
Homeopathic Hospital, Pittsburg, Pa.
- SISTER M. STANISLAUS, Supt., (1908)
Mercy Hospital, Wilkesbarre, Pa.
- REV. W. S. STEEN, M. D., Supt., (1902)
Presbyterian Hospital, Philadelphia, Pa.
- EWELL STOCKDALE, M. D., Supt., (1902)
Sunny Rest Sanatorium, White Haven, Pa.
- LYDIA WEBSTER STOKES, M. D., Supt., (1909)
Woman's Southern Homeopathic Hospital,
Philadelphia, Pa.
- DANIEL D. TEST, Supt., (1900)
Pennsylvania Hospital, Philadelphia, Pa.
- CHAS. E. THOMPSON, M. D., Supt., (1909)
Scranton Private Hospital, Scranton, Pa.
- MISS L. G. TOWNSHEND, Supt., (1907)
Columbia Hospital, Columbia, Pa.
- MISS MARY J. WEIR, Supt., (1908)
Braddock General Hospital, Braddock, Pa.
- C. D. WILKINS, M. D., Supt., (1908)
City Hospital, Wilkesbarre, Pa.
- MISS MARGARET S. WILSON, Supt., (1905)
Philadelphia Orthopedic Hospital, Philadelphia, Pa.

SIMON WINDKOS, M. D., Supt., (1909)
Mt. Sinai Hospital, Philadelphia, Pa.

PHILIPPINE ISLANDS (1)

HARRY E. SMITH, Supt., (1909)
Baguio Division Hospital, Baguio, Benguet, P. I.

RHODE ISLAND (8)

W. L. LINCOLN BATES, M. D., Supt., (1908)
Dr. Bates' Sanatorium, Providence, R. I.

MISS MARGARET S. BELYEA, Asst. Supt., (1908)
Butler Hospital, Providence, R. I. (*Associate.*)

G. ALDER BLUMER, M. D., Supt., (1909)
Butler Hospital, Providence, R. I.

ARTHUR H. HARRINGTON, M. D., Supt., (1905)
Rhode Island State Hospital for Insane, Providence, R. I.

JOHN M. PETERS, M. D., Supt., (1901)
Rhode Island Hospital, Providence, R. I.

A. W. PETT, M. D., Supt., (1908)
Wage Earners' Emergency Hospital, Providence, R. I.

MISS IMOGENE SLADE, Assistant Supt., (1909)
Woonsocket Hospital, Woonsocket, R. I. (*Associate.*)

GEO. F. WHITE, M. D., Supt., (1909)
Channing Hospital, Providence, R. I.

SOUTH CAROLINA (6)

A. EARLE BOOZER, M. D., Supt., (1909)
Columbia Hospital, Columbia, S. C.

MISS MARY CLARKE FERGUSON, Supt., (1908)
Columbia City Hospital, Columbia, S. C.

MISS LEILA V. JONES, Supt., (1908)
Roper Hospital, Charleston, S. C.

R. S. LIGIN, Trustee, (1909)
Anderson County Hospital, Anderson, S. C.

MISS MARY E. STELLING, Supt., (1908)
Anderson County Hospital, Anderson, S. C.

MISS CORA J. WELKER, Supt., (1909)
Knowlton Hospital, Columbia, S. C.

SOUTH DAKOTA (1)

H. R. HUMMER, M. D., Supt., (1909)
Asylum for Insane Indians, Canton, S. D.

TENNESSEE (2)

MISS JEANETTE M. PAULUS, Supt., (1907)
Knoxville General Hospital, Knoxville, Tenn.

MISS KATHERINE M. SHALTO, Asst. Supt., (1909)
National Soldiers' Home, Tennessee. (*Associate.*)

TEXAS (6)

MRS. JENNIE S. BEATTIE, (1908)
1220 Hemphill St., Fort Worth, Tex.

MISS MILDRED BRIDGES, Supt., (1908)
Thompson & Johnson Sanatorium, Fort Worth, Tex.

MISS WILMA CARLTON, Assistant Supt., (1908)
Temple Hospital, Temple, Tex. (*Associate.*)

MISS A. LOUISE DIETRICH, Supt., (1909)
St. Mark's Maternity Hospital, El Paso, Tex.

B. J. ROBERT, Supt., (1909)
Texas Baptist Memorial Hospital, Dallas, Tex.

J. R. STUART, M. D., Trustee, (1908)
Houston Infirmary Sanatorium, Houston, Tex.

UTAH (3)

SISTER M. LIDWINA, Supt., (1908)

Holy Cross Hospital, Salt Lake City, Utah.

T. S. PENDERGRASS, Supt., (1908)

Saint Mark's Hospital, Salt Lake City, Utah.

JOHN WELLS, Supt., (1906)

Latter Day Saints' Hospital, Salt Lake City, Utah.

VERMONT (2)

MISS MARY A. BURNS, Supt., (1908)

St. Albans Hospital, St. Albans, Vt.

MISS ELSIE P. MCCLOSKEY, Supt., (1908)

Brattleboro Memorial Hospital, Brattleboro, Vt.

VIRGINIA (3)

MISS A. COUSINS MCKAY, Supt., (1909)

Alexandria Hospital, Alexandria, Va.

MISS M. A. NEWTON, Supt., (1904)

Sara Leigh Hospital, Norfolk, Va.

MISS ROSE Z. VAN VORT, (1907)

Memorial Hospital, Richmond, Va.

WASHINGTON (4)

MRS. MAYME E. BARRY, Pres., (1908)

Walla Walla Hospital, Walla Walla, Wash.

A. J. BURROWS, Supt., (1909)

Fannie C. Paddock Memorial Hospital, Tacoma, Wash.

MISS EVELYN H. HALL, Supt., (1907)

Seattle General Hospital, Seattle, Wash.

MISS EDITH WELLER, Supt., (1909)
Northern Pacific Hospital, Tacoma, Wash.

WEST VIRGINIA (6)

A. S. BOGGS, M. D., Supt., (1907)
Boggs Hospital and Sanatorium, Gassaway, W. Va.

A. K. KESSLER, M. D., Supt., (1903)
Kessler Hospital, Clarksburg, W. Va.

MISS ELIZABETH LOUNSBERRY, (1901)
1119 Lee St., Charleston, W. Va.

ALPHA MILLETTE, Supt., (1907)
Reynolds Memorial Hospital, Glendale, W. Va.

MRS. MARY A. MORGAN, Supt., (1909)
Huntington City Hospital, Huntington, W. Va.

EDWARD P. SPARKS, M. D. Supt., (1907)
Miners' Hospital No. 2, McKendree, W. Va.

WISCONSIN (4)

J. W. COON, M. D., Supt., (1909)
State Tuberculosis Hospital, Wales, Wis.

MISS ELLA C. INGWERSON, Supt., (1907)
La Crosse Hospital, La Crosse, Wis.

B. LEIDERSDORF, Chairman, Executive Committee (1909)
Columbia Hospital Assn., Milwaukee, Wis. (*Associate.*)

F. M. SCHULZ, M. D., Supt., (1907)
Milwaukee County Hospital, Wauwatosa, Wis.

HONORARY MEMBERS.

- 1899
DEL T. SUTTON.....Detroit, Mich.
157 Alexandrine W.
- 1901
ROBERT W. HILL.....Albany, N. Y.
Capitol Bldg.
- 1902
BYRON W. CHILD.....Albany, N. Y.
Capitol Bldg.
- 1903
FRANK MILES DAY.....Philadelphia, Pa.
801 Penn. Mutual Bldg.
- 1903
FRANKLIN B. KIRKBRIDE.....New York, N. Y.
37 Madison Ave.
- 1904
HERBERT G. STOCKWELL.....Philadelphia, Pa.
833 Land Title Bldg.
- 1904
PROF. S. HOMER WOODBRIDGE.....Boston, Mass.
Institute of Technology.
- 1904
CHAS. G. DARRACH.....Philadelphia, Pa.
1430 South 58th St.
- 1904
J. M. MOSHER, M. D.....Albany, N. Y.
170 Washington Avenue.
- 1905
SIR HENRY BURDETT, K. C. B., K. C. V. O...London, Eng.
Porchester Square, W.
- 1906
FRANK J. FIRTH.....Philadelphia, Pa.
716 Arcade Bldg.
- 1907
R. W. BRUCE SMITH, M. D.....Toronto, Ont.
Parliament Bldg.
- 1907
C. W. PARDEE.....Buffalo, N. Y.
Delaware Ave.
- 1908
DONALD J. MACKINTOSH, M. B., M. V. O...Glasgow, Scot.
Western Infirmary.

CONSTITUTION.

ARTICLE I.

The name of this Association shall be "The American Hospital Association."

ARTICLE II.

The object of this Association shall be the promotion of economy and efficiency in hospital management.

ARTICLE III.

Membership.

Section 1. The membership of this Association shall be active, associate and honorary.

Sec. 2. Active members shall be those who at the time of their election are trustees or executive heads of hospitals, without reference to sex, title, or denomination. Any person, once an active member, may continue such membership subject to all rules pertaining to membership.

Sec. 3. Associate members shall be executive officers of hospitals next in authority below the superintendent, contributors to, or officers or members of associations, the object of which is the foundation of hospitals or the promotion of the interests of organized medical charities. Associate members shall not have the right to vote.

Sec. 4. All applications for membership shall be in writing, and addressed to the Secretary, and shall be endorsed by one or more members of the Association. They shall

be referred by the Secretary to the Committee on Membership for examination and report. The candidate shall be notified of the result. If elected, he shall become a member of the Association on payment of an initiation fee of \$5.00, which shall also cover his first dues.

Sec. 5. Honorary membership may be suggested at any meeting of the Association by any member for any person whose services, public or private, may entitle him to such recognition, or for any other person who, in the judgment of the Association, is entitled to such membership.

Sec. 6. Honorary members shall have all the privileges of active members, except voting. They shall be exempt from the payment of dues.

ARTICLE IV.

The executive officers of the Association shall consist of a President, three (3) Vice-Presidents, a Secretary and a Treasurer.

ARTICLE V.

The executive officers shall be elected at each Convention, and shall serve until the close of the Convention next succeeding, or until their successors are regularly elected and installed.

ARTICLE VI.

All vacancies occurring in executive offices between Conventions shall be filled by the Executive Committee.

ARTICLE VII.

Amendments to the Constitution shall be submitted in writing. Amendments cannot be acted upon at the session at which they are proposed, but may be at any subsequent session. They shall be passed by not less than two-thirds vote of the members present and voting.

BY-LAWS.

ARTICLE I.

Meetings.

Section 1. The regular meetings of the Association shall be held at the places and on the dates fixed by the Convention or the Executive Committee of the Association. This committee, in conjunction with the President and Secretary, shall also arrange the programs for the Conventions.

Sec. 2. Special meetings may be called by the President, or, in his absence, by a Vice-President, upon the written petition of not fewer than ten (10) members. This petition shall recite the object of the call. The President, through the Secretary, shall give notice of not less than sixty (60) days before the proposed time of such special meeting to each member of the Association, which notice shall also recite the object of the meeting.

Sec. 3. A quorum of the Association shall consist of not fewer than thirty (30) members.

ARTICLE II.

Elections.

Section 1. All officers shall be elected by ballot, excepting where it is otherwise ordered.

Sec. 2. A majority of the votes cast shall constitute an election.

Sec. 3. Only active members shall be entitled to vote.

ARTICLE III.

Duties of Officers.

Section 1. The President shall preside at all meetings of the Association. He shall appoint all committees unless,

by vote of the Association, other provision shall be made. He shall be, *ex-officio*, a member of all standing and special committees.

Sec. 2. The Vice-Presidents shall, in the order of their rank, in the absence of the President, perform his duties.

Sec. 3. The Secretary shall keep the Minutes of the meetings and the records of the Association in a book provided for these purposes. The Secretary shall furnish to the Committee on Publication, within ten (10) days after the adjournment of the regular Convention, a correct copy of the Minutes thereof for publication in the "Proceedings." The Secretary shall be allowed not to exceed the sum of \$360 per annum to defray cost of clerical assistance.

Sec. 4. The Secretary shall conduct the correspondence of the Association, and shall keep on file all letters and all correspondence, together with all replies thereto.

Sec. 5. The Treasurer shall receive all dues and other moneys of the Association, and shall pay all bills approved by the President and Secretary, and shall submit these accounts, together with a financial report, at the regular meeting of the Auditing Committee, after which he shall present this report, with the endorsement of the Auditing Committee, to the Convention. The Treasurer shall be allowed not to exceed the sum of \$120 per annum to defray cost of clerical assistance.

ARTICLE IV.

Committees.

Section 1. The President elected at the regular Convention shall appoint the following standing committees: An Executive Committee of five (5) members; an Auditing Committee of three (3) members; a Committee on Nomination of Officers of three (3) members; a Membership Committee of three (3) members; a Committee on Constitution and Rules of three (3) members; a Committee on Hospital Progress of six (6) members; and a Committee on the Development of the Association of three (3) members.

Sec. 2. The Auditing Committee shall receive and audit all accounts of the Treasurer and all bills contracted on account of the Association, stamp its approval thereon, and return them to the Treasurer for submission to the Convention.

Sec. 3. The Committee on Nomination shall nominate to the Convention the names of candidates for President, three (3) Vice-Presidents, Secretary and Treasurer. The action of this committee is at all times subject to the approval of the Convention.

Sec. 4. The Membership Committee shall receive and consider all names of candidates proposed for membership, and shall report results to the Convention for final action.

Sec. 5. The Committee on Constitution and Rules shall consider and report on all proposed amendments in the Constitution and By-Laws and all Rules of Order.

Sec. 6. The Committee on Hospital Progress shall observe the development of hospital work in the United States and Canada, and shall submit a report of its observations at the Annual Convention of the Association.

The Committee on Hospital Progress shall be subdivided as follows:

- (a) A committee of one on hospital construction;
- (b) A committee of one on hospital efficiency, hospital finances and the economics of administration;
- (c) A committee of one on medical organization and medical education;
- (d) A committee of one on the training of nurses.
- (e) A committee of one on out-patient work.
- (f) A committee of one on hospital accounting.

Section 7. The Committee on the Development of the Association shall present annually a report on the further development of the association's work.

ARTICLE V.

Dues.

Section 1. The dues of active members shall be Five Dollars (\$5.00); the dues of associate members shall be

Two Dollars (\$2.00). Dues shall be paid to the Treasurer of the Association on or before each regular meeting of the Association.

Sec. 2. Any member delinquent in his dues more than two (2) successive Conventions shall, upon the report of the Treasurer of adequate notification, be suspended from membership.

Sec. 3. The Treasurer shall notify the delinquent of such suspension, and at the same time the Secretary of the Association, who shall enter it upon the records.

Sec. 4. Any delinquent may reinstate himself upon payment of all back dues, as well as those for the ensuing Convention.

ARTICLE VI.

Publication of Proceedings.

Section 1. The President shall appoint three active members of the Association as a Publication Committee, one of whom shall be the Secretary of the Association. It shall be the duty of this Committee to edit and publish the annual transactions of the Association.

Sec. 2. The Secretary shall furnish each active and honorary member a copy of this publication.

Sec. 3. The Treasurer shall, upon the certification of the President and Secretary, pay all bills for the printing and publication of the Proceedings of the regular Conventions.

ARTICLE VII.

Guests.

Members of this Association may have the privilege of inviting special guests to the meetings, with the consent of the President. Guests thus introduced shall be permitted to participate in the discussions.

ARTICLE VIII.

Discipline.

Section 1. All charges of violation and infraction of rules or unbecoming conduct shall be referred to a special investigating committee appointed by the President.

Sec. 2. Due notice of the charges shall be given to the alleged offender, in writing, by the Secretary of the Association.

Sec. 3. The Association shall have the right and authority to reprimand, suspend, and expel any member guilty of violation of any of the provisions of the Constitution or By-Laws of the Association, after a full and fair investigation shall have been made.

Sec. 4. A four-fifths vote shall be necessary to sustain the action of such committee.

ARTICLE IX.

Order of Business.

Calling of the Association to order.

Reading of Minutes of previous Convention.

Announcements. Unfinished Business.

Reports of Committees.

New Business.

Presentation of Papers, and Discussion.

ARTICLE X.

Amendments to By-Laws.

No part of these By-Laws shall be suspended, altered, or changed, except as provided for by Article VII. of the Constitution.

MINUTES OF THE ELEVENTH ANNUAL CON-
FERENCE OF THE AMERICAN HOSPITAL
ASSOCIATION.

HELD AT WASHINGTON, D. C.,

SEPT. 21, 22, 23, 24, 1909.

TUESDAY, SEPTEMBER 21—MORNING SESSION.

The convention met at the New Willard Hotel, John M. Peters, President of the Association, in the chair.

PRESIDENT: The meeting will come to order. I will ask the Rev. G. C. F. Bratenahl, D. D., of this city, to deliver the invocation.

REV. G. C. F. BRATENAHL: O, God, our Heavenly Father, to whom alone we look for strength, in whose hands are youth and age, and strength and weakness, and life and death, behold, we beseech Thee, with Thine eyes of mercy, these Thy servants, the members of this American Hospital Association, whose skill to heal cometh only from Thee. Thou causeth the earth to bring forth the herb of the field, Thou givest the treasures of the rock and the healing waters; to Thee alone we owe it that the earth is full of balms, which man can use. Endow, we beseech Thee, these physicians and all members of this Association with greater knowledge, that so by diligence in study, and faithfulness to Thee, Thy Holy Spirit may increase their skill, to Thy honor and glory and to the relief of Thy sick children. And, especially, we pray Thee that Thou wilt grant Thy grace to the deliberations of this assembly. Give Thy servants an increase of the spirit of wisdom, of knowledge, and of understanding; keep far from them ignorance, pride and prejudice, and of Thy great mercy, we beseech Thee, vouchsafe so to direct, sanctify and govern them in their work and in their counsel, by the mighty power of the Holy

Spirit, that they may ever more and more relieve the sufferings of thy servants in this world.

To Thy honor and glory we ask it, through Jesus Christ, our Lord. Amen.

PRESIDENT: We have received great assistance this year from members of the Army and Navy Medical departments. I want personally to thank the men in these departments for their aid. Among those who are good enough to take the time to come here, especially to come and offer us greetings, is Rear Admiral Presley M. Rixey, Surgeon-General, United States Navy. I take pleasure in introducing Dr. Rixey.

ADDRESS OF GREETING TO THE AMERICAN HOSPITAL ASSOCIATION.

SURGEON-GENERAL P. M. RIXEY, U. S. N.

Mr. President and Members of the American Hospital Association: In anticipation of the opening of this Congress and the small role which it is my pleasant lot to play in the proceedings, I have been led to contemplate the purposes of your organization—"The Promotion of Economy and Efficiency in Hospital Management," with an attention which has stirred the deepest interest.

But beyond the intent of your watchwords, there are other considerations inseparable from the full import of your organization. It can not be questioned that one of the most striking characteristics of the age is a wide movement toward humanitarianism, and it is in these United States that the compelling tendency has its center and finds its greatest force, notwithstanding that reputation for commercialism, which often so blinds the outside world to our gentler virtues. We can afford, however, to repose an abiding faith in that great arbiter "time," for those who study our record and watch our career will learn, what *we now* know, that money is but the means to an end, and that our business enterprise is equalled by our philanthropic endeavor. Yet that very spirit of commerce with which this country is so abundantly credited has been productive of a direct benefit to our institutions and has enhanced our power in the great work for the welfare of mankind. In fact commercialism is the parent of that realized necessity to order our methods upon a basis in accordance with the demands of our growing concerns and in keeping with the light of our day, and the movement toward thorough and efficient organization for the utmost good in every undertaking is, therefore, another striking characteristic of the age.

The American Hospital Association assembled here in its Eleventh Annual Conference, to me seems symbolic of all that is best in these two ideas,—humanitarianism, of the most vital and practical nature, as its guiding consideration, and improved organization, in all the various ramifications of the work which it represents, as a means of insuring the fullest possible accomplishment of its aims. The object which animates this association could not be more worthy. The work which lies before the meeting, as expressed in the official programme, is eminently deserving of the solicitous interest of all fellow countrymen, particularly your professional colleagues and co-workers, in the effort to better the conditions of life generally—not only, by actually healing the sick, but in exerting a potent influence toward the development of what has been aptly termed a “health conscience.” It is these more intimate associates in such ministrations who entertain an understanding appreciation of the importance of the problems, which are receiving your careful attention and best judgment and to which you are devoting your energies. I count it a great distinction that I am able to identify myself with you in this splendid work, and I esteem it a high honor to have been accorded the privilege of extending a welcome. On behalf of the medical fraternity of the District of Columbia and my colleagues of the Army and Naval and Public Health and Marine-Hospital Services, I beg to express the warmest greetings and to wish you God speed in your discussions and deliberations.

No one is more keenly alive than I to the improvement which this association has accomplished in the organization and administration of hospitals during the eleven years of its existence, and though there is much still to be done, the distinguished and varied constituency of the association gives a sufficient earnest of its capacity to efficiently cope with the innumerable, and often puzzling, questions relating to the character and construction of hospitals; the financing of them, the system of records, the training and regulation of nurses, the medical and lay staff, the efficient but economical equipment and administration, the relation of the hospital to the patient or public, and vice versa, in point of sup-

port—in fine, all the manifold responsibilities incident to “the many sidedness of hospital work.”

“The difference in administration of military and civil hospitals” is a subject which is to be presented in the course of your meeting, and will doubtless be considered both ably and at length. It would be an inappropriate anticipation of your programme, therefore, and beyond the scope of my legitimate remarks to say more than a few words concerning my own immediate interest in all that pertains to hospitals.

A brief general reference to the hospital feature of the Medical Department of the Navy must suffice to indicate the reality of this interest, and perhaps you will gain some conception of its breadth, also, when you are told that the responsibilities of the Bureau of Medicine and Surgery include the supervision of—not one, but a system of eighteen hospitals, scattered over the United States and in various parts of the world beyond the continental limits of this country, representing a capacity of 1,700 beds; that many of these hospitals have been and are undergoing extensive renovation and enlargement during a continuous occupation—a fact which has complicated administration; that the system of administration is being revised and adapted to new conditions; and that new hospitals are being or are about to be constructed at home and abroad—one at Portsmouth, N. H., one at Boston, Mass., one at Newport, R. I., one at Chicago, Ill., one at Pearl Harbor, Hawaii, and one at Baguio, P. I. When these are completed the capacity of Naval hospitals will have been increased to about 2,500 beds and the service in this respect will be proportionate to growing requirements and thoroughly up-to-date in character—both, as regards equipment and construction. You are to hear a “description of the new Naval Hospital” at Chicago, Ill.; and, though the plan of this institution differs in some particulars from the usual design of other new Naval Hospitals, it is representative of the high standard which we have striven to attain in the establishment and modernizing of hospital provisions for the Navy.

The Army, Public Health and Marine-Hospital Service and the civil profession of the District also have large hospital responsibilities and are equally concerned in your work, so that in assuming to speak for them as well as my own service, I feel confident that you will be conscious of the sincerity of this greeting.

In conclusion, I beg to assure you that those of us who will not be able to participate in the important part of your programme or to attend your professional sessions, even in the capacity of auditors, will await with interest the results of your conference and the publication of the valuable papers which are to be read. We offer heartfelt wishes for the utmost success in the purposes for which you have foregathered.

In this connection it may be of interest to the association to state that on Saturday last bids were opened for hospitals at Chelsea, Mass., Newport, R. I., and Portsmouth, N. H., the lowest bid being \$2,200.00 per bed; the capacity of each hospital 127 beds. The plans and specifications for the three hospitals require a high grade of work, such as marble finish and metal doors for operating suite, cast iron base parts, ample system accommodations for the future, face brick finished in all basements, special hard finish for all plaster, sterilizing hoppers for each ward, ample open air pavilions and open air sun parlors, and complete examination and laboratory facilities.

PRESIDENT: It is customary for the Association to hear an address from the President. This is now in order. (See page 138.)

PRESIDENT: I want to call the attention of the members to the exhibit of charts and printed matter from general hospitals and other institutions, as shown in the Secretary's office. Miss Anderson, of the N. E. Baptist Hospital, Boston, has taken a great deal of time and trouble to get this thing together; and I know that all of us can learn

much from this exhibit. I personally want to thank Miss Anderson for the great work involved.

It has been customary at the first session of this Association for the President to appoint a committee to consider the time and place of the next meeting. I will name as such a committee Mr. Asa Bacon, Dr. J. N. E. Brown, and Mrs. Gertrude Gibson, who will report on this matter at some future session, probably Thursday.

PRESIDENT: We have many invitations from the managers and superintendents of institutions in Washington. I have not a list of them, but I feel very sure that our members will be welcome at all institutions in the city or the District. The Naval Medical School and Hospital has something worth showing, and I think all of our members can pay a visit to that institution with profit.

Adjourned to meet at 8 p. m.

TUESDAY, SEPTEMBER 21—EVENING SESSION.

PRESIDENT: Dr. Ancker, who was to have taken charge of the Question Box session, is not able to attend, and Dr. Hurd, of Johns Hopkins Hospital, has kindly consented to act as chairman. I wish all members would put in writing and send to Dr. Hurd, or give to the Secretary, any questions that they would like to have discussed on the floor.

The first paper of the evening is entitled "The Differences in Administration of Military and Civil Hospitals," by Lieut.-Col. William H. Arthur, Medical Corps United States Army. (See page 153.)

PRESIDENT: The next paper is number three on our program: "Hospitals from the Patient's Point of View," by Dr. W. Gilman Thompson, New York. Dr. Thompson is unable to be here, and Dr. J. B. Howland, of the Massachusetts General Hospital, of Boston, has kindly consented to read it. (See page 160.)

PRESIDENT: The next paper is by Mr. Homer Folks, entitled "The Many Sidedness of Hospital Work." Mr. Folks is secretary of the State Charities Aid Association, of New York. (See page 166.)

PRESIDENT: I am sure we are very much obliged to both speakers this evening, and to Dr. Thompson, for giving us different points of view of institutional work. I am positive that all of us will take away from this meeting suggestions and ideas that do not generally occur to us in our daily routine.

PRESIDENT: We have received invitations to visit the Episcopal Eye and Ear Hospital of this city and have also received a letter from the Hudson-Fulton Celebration Commission, of New York. General Franclyn E. Davis, M. D., writes as follows:

September 20, 1909.

To the President of the Hospital Superintendents Association, Washington, D. C.

MY DEAR SIR:—

I take pleasure in extending to you an invitation to visit the Field Hospitals of the National Volunteer Emergency Service, erected in connection with the Hudson-Fulton Celebration Committee in New York City.

This may be interesting from the fact that you may be called upon some day to plan just such an affair.

Trusting I may have the pleasure of meeting you all, believe me,

Very cordially yours,

FRANCLYN E. DAVIS, M. D.,
The Adjutant-General N. V. E. S.

PRESIDENT: Has any member any matter of new business to bring up at this meeting? If there is no more business to be transacted, a motion to adjourn is in order.

Convention adjourned to meet at 10 a. m. Wednesday.

WEDNESDAY, SEPT. 22—MORNING SESSION.

PRESIDENT: Dr. Ranney, of the Lakeside Hospital, Cleveland, is not here, and I am going to appoint Mr. J. R. Coddington to act with Mr. Symington on the Committee on Constitution and By-Laws. There are some amendments that are to be brought up, and if a member has any amendment in mind I wish he would bring it to the attention of Mr. Symington.

The Secretary has a letter from Miss Aikens, which I will ask him to read at this time.

SECRETARY BABCOCK: This communication from Miss Aikens refers to the Handbook on Hospital Management that she has been working on for some time, and which she wished to be brought before the convention.

The need has long been felt and often expressed, for a concise handbook on hospital management, something of convenient size and moderate price which could be recommended to new trustees and superintendents and younger students of hospital administration. Within the past year an effort has been made to provide such a book. An outline of the text was made out and submitted to several of the older members of the association for suggestions and approval of the general plan. The proposition was made and agreed to, to secure a corps of contributors who would each become responsible for a section of the book—all profits accruing from the sales to be turned into the treasury of the association. Thus far no objection has been made to the plan.

Those who have promised to contribute are Drs. Hurd, Brown, Goldwater, Peters, Babcock, Washburn, Howland, Ross, Howell, Messrs. Gilmore, Ludlam and Gill and Misses Anderson, Coleman and Aikens.

A considerable part of the manuscript for the book is already in hand. The remainder is expected to be ready within the next few months and it is hoped that plans for publishing may be undertaken early in the new year. The book is now offered to the association, to be accepted or rejected. The book will be published whether or not the association decides to accept the profits. It is hoped it may be possible to publish it at a price not exceeding four dollars a copy, and probably not less than three dollars, but the price cannot be accurately determined till all the copy, photos, plans, etc., are in. It is expected to be well illustrated and, in every way practical.

If the book is accepted by the association it will be in order at this meeting to appoint an editorial committee and authorize whatever contracts may be necessary for its publication."

PRESIDENT: I would be glad to hear the views of the members on this subject.

DR. HOWELL, New York: I am interested in this book, because I am one of the contributors and would like to see it printed, but I think it should remain a private enterprise. I do not think the society should take it up, and I hope the society will vote to reject this proposition.

REV. W. S. STEEN, Philadelphia: I very much question the advisability of this society taking the responsibility for this publication. I would not be in favor of it myself.

REV. DR. KAVANAGH: Would not a motion something like this answer the purpose:

"It is the sense of this Association that it would be

unwise for it to undertake the publication or the responsibility of publishing the handbook edited by Miss Aikens. We believe that a book of this character is needed and the Association hopes that Miss Aikens will be able to publish this work herself."

The motion was duly seconded.

DR. BROWN: Would it not be wise to refer this matter to a committee which might be appointed by the President with a view to reporting as to the wisdom of the whole matter?

PRESIDENT: Miss Aikens, in her generosity, offers to turn over the proceeds, if there are any, to the treasury of this Association. I think her idea is right. Whether the articles that will appear in this book are worth while, remains to be seen, but I do not think, from what I know of Miss Aikens and the members who are writing articles that will appear in this book that she has any selfish motives.

DR. BROWN, Toronto: Is there any objection to the President appointing a committee to report on it?

PRESIDENT: There is no objection.

DR. BROWN: I have no right to press my amendment at this time, unless the gentlemen will yield.

REV. DR. KAVANAGH, Brooklyn: I would be very glad to accept that amendment.

DR. BROWN: Then, sir, I move that a committee of three be appointed to report as to what action shall be taken regarding it.

The motion was carried.

PRESIDENT: Is there any new business to be brought up at this session? If not, we will proceed to the reading of the paper which was to have been read last evening—that of Mr. Del T. Sutton, editor International Hospital Record, entitled "The Hospital and the Public." Mr. Bailey will read this paper. (See page 176.)

PRESIDENT: The next paper is by Dr. Frederick Brush, superintendent New York Post-Graduate Medical School and Hospital, New York City, entitled "The Hospital and the Patient of Moderate Means." (See page 181.)

PRESIDENT: I wish to suggest to the members that they take notes, or make at least a mental note, of these papers,

as they are read, so that they may be able to discuss them more intelligently when the reading is finished.

DR. BEARD, Minneapolis: I should like to make a point, if possible, as a matter of privilege, with reference to this discussion. We have a method of attacking the discussion which I have never seen adopted elsewhere, and which seems to me to be quite undesirable. Oftentimes the features of the paper are brought out in the discussion, and the discussion is frequently the most effective part of the contribution. We have just had two very effective papers, of very different points of view. One was a paper of criticism largely, the other was a paper of constructive suggestion, but by the time we get through with the reading of all the papers, we have absolutely no points of contact, and our discussion fails. I suggest that it might be desirable to modify the program and discuss these things as we go.

PRESIDENT: The point raised is a good one, and I think we might as well begin now, and have these papers discussed directly after the reading.

DR. BEARD: I make a motion to that effect, that the discussion be immediately after the presentation of the papers.

The motion was carried.

PRESIDENT: If there is no further discussion of these papers, we will listen to Dr. Howell, superintendent of the New York Hospital, who is to read a paper on "A Cost System for Hospitals." (See page 193.)

PRESIDENT: We will proceed to the next paper, by Dr. Sarasen, entitled "The Terraced Pavilion, a New System for the Construction of Hospitals and Sanitoria." It will not be read, but will be published with charts, in detail, in the transactions. (See page 217.)

The next paper of the session is by Dr. S. S. Goldwater, of the Mt. Sinai Hospital, of New York City, who will read his paper on "The Appropriation of Public Money for the Partial Support of Voluntary Hospitals in the United States and Canada." (See page 242.)

PRESIDENT: I wish to announce the appointment of a committee to take up the desirability of publishing Miss

Aikens' book. I will appoint Mr. Briggs, Miss Keith and Dr. Howell.

If there is no further business to be brought up, we will declare this meeting adjourned until 8 o'clock tonight.

WEDNESDAY, SEPT. 22—EVENING SESSION.

PRESIDENT: We have a letter here from Col. Arthur, which I will ask the Secretary to read.

SECRETARY BABCOCK: Unfortunately, reporters who report the proceedings of conventions like this are not medical men and they frequently make some unfortunate mistakes or misquotations in their reports. This is an example:

WALTER REED ARMY GENERAL HOSPITAL,

Washington, D. C.

September 22, 1909.

DEAR SIR:—

Will you kindly contradict the report in this morning's Washington Post, of the very short and unsatisfactory paper I read last night. The opinions attributed to me in that remarkable paragraph I not only did not express, but they are the exact reverse of what I really entertain, and we army doctors regard as our models of system, method and discipline the great civil hospitals, and are constantly visiting them to get suggestions and ideas.

If I had entertained any such opinions as this article credits me with (and I certainly do not), it would have been grossly discourteous in me to have expressed them in such a meeting. But my paper, such as it is, proves me innocent of expressing any such absurd ideas as the Post attributes to me.

Yours very truly,

WM. H. ARTHUR,

Lieut.-Col. U. S. A. Medical Corps.

To Dr. John M. Peters,

President American Hospital Association.

PRESIDENT: The first paper of the evening has been written by R. W. Corwin, superintendent of Minnequa Hospital, Pueblo, Colorado. Dr. Corwin wrote me some days ago that he was unable to come, very much to his regret, but he was kind enough to forward his paper. Dr. Brown, of the Toronto General Hospital, will read it. (See page 295.)

PRESIDENT: The next is by Dr. Charles P. Emerson, superintendent of the Clifton Springs Sanatorium, Clifton Springs, N. Y., "The Relation Between the Architect and the Doctor in Planning a Hospital." (See page 305.)

PRESIDENT: We regret very much to announce that Mr. Bertrand E. Taylor, who was to have written a paper for this meeting, died two months ago, and did not complete the paper that he expected to prepare for the conference.

The next paper is by Rear Admiral A. Ross, of the United States Navy, entitled "Description of the New Naval Hospital, North Chicago, Ill." This will be illustrated by stereopticon. (See page 318.)

PRESIDENT: I am sure we are all very much obliged to Admiral Ross for the thoughtful exposition he has given of his wonderful plans. The final paper of the evening is by Dr. Howard, of the Peter Bent Brigham Hospital, Boston. He was to have reported tomorrow, but it was thought best to bring all papers on this subject together at this time. (See page 333.)

THURSDAY, SEPTEMBER 22—MORNING SESSION.

PRESIDENT: We will listen to the report of the Membership Committee, which will be presented by Dr. Elder.

REPORT OF THE MEMBERSHIP COMMITTEE.

One hundred and seventy applications for membership were received by the Secretary during the year and presented to the Membership Committee for their approval. Of the active members, twenty-four were trustees of hospitals or members of hospital association boards, one hundred and forty-nine were active members, and twenty-one were associate members.

The new members can be credited to the following states and provinces:

Alabama 1, Arizona 1, California 9, Connecticut 3, Canada 8, District of Columbia 5, Georgia 1, Hawaiian Islands 1, Illinois 4, Indiana 4, Iowa 2, Kansas 1, Kentucky 2, Louisiana 1, Maine 2, Maryland 7, Massachusetts 19, Michigan 6, Minnesota 8, Mississippi 1, Missouri 6, Nebraska 6, New Mexico 3, North Carolina 4, New Jersey 1, North Dakota 1, New York 28, Oklahoma 5, Ohio 3, Oregon 1, Pennsylvania 14, Rhode Island 3, South Carolina 1, South Dakota 3, Texas 1, Virginia 1, West Virginia 1, Washington 2. Total, 170.

The Secretary informs us that in addition to the 170 new members admitted during the year, there are in good standing, 458 members, including 15 honorary members, making a total membership of 628.

E. B. ELDER, M. D.,

J. N. E. BROWN, M. D.,

LUCIA A. JAQUITH,

Membership Committee.

PRESIDENT: You have heard the report of the Membership Committee. If there are no objections it will stand recorded and passed to file with the Secretary.

The next in order is the report of the Treasurer, Mr. Bacon.

TREASURER'S REPORT FOR THE YEAR ENDING SEPT. 23, 1909.

Receipts.

Membership fees and dues.....	\$1,571.00
Dr. John M. Peters, account of Training School Committee	91.95
Cash balance Sept. 24, 1908.....	1,268.80
	<hr/>
	\$2,931.75

Disbursements.

Printing	\$ 834.35
Clerical and stenographic work.....	331.30
Training School Committee.....	591.95
Postage	186.93
Express	13.75
Telegrams	9.70
Toronto convention	74.45
Exchange on checks.....	11.45
Books for Treasurer.....	2.30
Sundries	5.50
Cash balance Sept. 23, 1909.....	870.07
	<hr/>
	\$2,931.75

ASA BACON, *Treasurer.**Audited, checked with vouchers and found correct.*

F. E. MOULDER,

EMMA A. ANDERSON,

Auditing Committee.

PRESIDENT: You have heard the report of the Treasurer. What action will the members take on this report?

It was moved and carried that the report be accepted.

PRESIDENT: There have been some amendments to the Constitution proposed, and we will listen to the reading of those amendments by Mr. Symington.

MR. SYMINGTON, Norwich, Conn.: The following amendments have been handed to the Committee on Constitution and By-Laws:

Amend Section 1, Article 6, as follows: *"The President shall appoint three active members of the Association as a Publication Committee, one of whom shall be the Secretary of the Association. It shall be the duty of this committee to edit and publish the annual transactions of the Association."*

Add to Section 1, Article 4: *"A Committee of three on Legislation."*

Add to Article 4 a new section, as follows: *"Section 8. The Committee on Legislation shall report annually to the Association on all national and state legislation of interest to hospitals or training schools."*

These amendments are approved by the committee.

PRESIDENT: Are there any other amendments to be proposed?

DR. GOLDWATER, New York: At every meeting of this Association for the last three or four years the suggestion has been made from all sides that the Association ought to have its headquarters serve as a bureau of information for everybody seeking information concerning hospitals. When the suggestion was first made, the Association was not strong enough numerically and financially to undertake the burden or support of such a headquarters. It seems to me after the showing made by the Membership Committee as to the progress of the Association with respect to new members, that we are now warranted in considering the establishment of such a bureau at once, on a moderate scale, beginning in such manner as to permit of further growth and development. We heard from Dr. Emerson in repetition of this suggestion, and this morning in conversation

with Dr. Ross, who has presented the report on Hospital Efficiency, Hospital Finance, and Economics of Administration, I was pleased to learn that Dr. Ross is to bring forward the same suggestion. I do not think we need to discuss the question as to who has the right of priority or discovery. I think the members generally agree that we ought to have such a bureau of information, and that the Association and its friends throughout the country will be prepared to support it. The first thing we shall have to have is a modification of the Constitution to make possible the renting of an office and the appointment of a permanent clerical assistant. The Secretary, who very generously gives his services, as I understand, is willing to continue to give his services to the Association, taking upon himself the added duty of directing the work of this bureau in its incipency. Ultimately, I hope the Association will be strong enough financially and numerically to have a liberally paid general secretary in charge of these general headquarters. As the headquarters grow, and the work increases in importance, requiring more and more attention, it will be necessary to formulate plans for controlling the work which is to center there. In the beginning, it seems to me that we need to do little more than to grant an additional appropriation for clerical hire, and arrange a change of by-laws to permit the establishment of the headquarters; and finally to determine upon a Committee of Organization during the coming year to consider especially how those newly-established headquarters are to be operated, and to work out a plan of development and arrangement with reference to future progress. After conferring with a number of officers and members of the Association last night, I drafted certain amendments to the Constitution, which have as their object the carrying out of this general plan, and those amendments I wish now to present to the consideration of the Association. It is suggested to modify Section 3, Article 3, of the By-Laws, to read as follows:

"The Secretary shall be in charge of the permanent headquarters of the Association and shall keep the minutes of the meetings and records of the Association.

*"The Secretary shall furnish, etc. * * **

"The Secretary shall be allowed not to exceed the sum of \$900 per annum to defray the cost of clerical assistance."

Modify Section 1, Article 1, to read as follows:

"The Association shall establish and maintain a permanent headquarters in which shall be deposited the official records of the Association and all books, pamphlets, plans, drawings, figures or other matter relating to the planning or administration of a hospital, or the conduct of organizations for medical relief, as may be acquired by the Association, either by gift or purchase. The Association shall appropriate annually not to exceed the sum of \$360 for office rent."

At the present time the special meetings may be called upon the recommendation and petition of five members of the Association. That provision doubtless was made at a time when the membership of the Association was less than a hundred. With the present membership exceeding 600, it would seem proper to change the minimum number of petitioners from five to ten, and it is suggested that Article 1, Sec. 2, be modified to read as follows:

"Special meetings may be called by the President or Vice-President, etc., upon the written petition of not fewer than ten members."

Section 3, of the same article, provides that a quorum shall consist of not fewer than ten members. That seems to be an exceedingly small number for an Association with the membership of ours, and I suggest a quorum shall consist of not less than thirty members.

These amendments to the Constitution are submitted for your consideration.

DR. HURD, Baltimore: I would move that these amendments be referred to a special committee to report at the next meeting of the Association.

DR. GOLDWATER: Is it not provided that such matters be referred to the Committee on Constitution at the same session?

PRESIDENT: I think ordinarily this would be referred to that committee, who would report at the next session, the next day.

DR. HURD: This involves a complete change in the organization of the Association; the institution from being an Association for mutual counsel and efficiency, is to become a great national organization, with a headquarters and a paid Secretary. We are not yet ready for it, and it seems to me that it needs to be threshed out very much more carefully than it has been in the Association up to this time.

PRESIDENT: As I understand, the matter will be laid over until the meeting tomorrow morning, when it will be up for consideration and discussion. We will now listen to the reading of a paper entitled "What Do Justice and Present Conditions Demand in the Way of Law and of Education of Nurses?" It is written by Dr. R. M. Phelps, assistant superintendent, Rochester State Hospital, Rochester, Minn. Miss Keith, of Rochester City Hospital, has been kind enough to consent to read this paper. (See page 345.)

PRESIDENT: Dr. Ancker, who was appointed to take charge of the Question Box, cannot be present, and Dr. Hurd, of Johns Hopkins Hospital, has kindly consented to act in his place.

DR. HURD: I am sorry that I did not receive the questions in time so that it would be possible for me to see any person to ascertain whether he or she would be willing to speak in reply to these questions. I must therefore ask you to volunteer. I hope no one will feel at all backward in speaking, because I am sure every person here has some knowledge which will be of benefit in the answer to all these questions.

Question 1. *"Is the vacuum cleaner perfectly practical and satisfactory for hospital use?"*

Dr. Mann, of Boston, is asked to speak on the subject of the vacuum cleaner.

DR. MANN, Boston: We put in a vacuum cleaner about two years ago. We sweep all our wards, walls and ceilings, and do all our high dusting with it. We think it is a success. This plan cost us in the neighborhood of \$3,000, and it does away with the raising of dust in the wards. I know

it is a success with us. We put it into our new contagious department we built last fall. I do not know that I can say any more about it, except that we like it, and think it is a success. We have two men start in every morning, one on the medical side and one on the surgical side, at seven o'clock, and sweep until eleven. Afternoons they are busy on the walls, the rugs and the high dusting. The rugs from the nurses' home are brought over every week and swept. The piping, as you know, is run the same as fire pipes, with an attachment on each floor and in some places two attachments. We have a length of hose on each floor to save transporting around the house.

DR. HURD, Baltimore: I should be glad to hear from Dr. Babcock in reference to the matter.

DR. BABCOCK, Detroit: Last year we investigated the possibilities of the vacuum cleaner, and I corresponded with a number of hospitals and hotels that were using them. We made ready to sign a contract with a company for the installation of a stationary cleaning plant, when our attention was called to a portable machine, of an unusually high grade, which was nearly noiseless. The trouble with the portable machines, heretofore, has been that they were too noisy to use in a hospital. The machine that we finally adopted is a high-grade portable machine, costing \$300.00 each. We have used them now for a period of eight or nine months with a great deal of satisfaction. With us, the stationary plant would have been more or less inconvenient, as it would have been necessary to run our piping up through the main corridors. As it is, we pipe from floor to floor in the elevator shafts or pipe shafts, and in that way obviate a large amount of piping which would disfigure the main corridors. We use two portable machines in three stationary positions, so that we can reach all parts of the hospital with 75 feet of hose. The portable machine has with it an extension arm for reaching the picture moldings and the ceilings of the rooms, and we can dust all parts of the rooms, with this apparatus.

A MEMBER: What is the name of that machine?

DR. BABCOCK: It is called the "Invincible," and is made in Pittsburg.

A MEMBER: Do you use electricity?

DR. BABCOCK: The question has been asked as to the motive power. It is provided with a motor, in the machine, but it is so enclosed that there is little noise from the motor that is apparent on the corridors.

DR. MANN: I should like to ask how many inches of vacuum you get on the cleaner of one of these portable machines, and how does it take care of the dust.

DR. BABCOCK: I do not know that I am able to state the number of inches of vacuum that can be obtained. It takes care of the dust in a portable chamber, which is detached from the machine. When the operator desires to clean the machine, the portable chamber (which does not weigh over 10 pounds and is made of galvanized iron), is picked up, detached carried out and emptied.

A MEMBER: Dr. Babcock, may I ask you this: If you were building would you advise portable or stationary cleaners?

DR. BABCOCK: The question is asked: "If we were building a new hospital would we install stationary or portable apparatus." I think we would investigate the stationary machines, and in all probability install one in the new hospital.

A MEMBER: Does your machine pick up the little rolls of lint that gathers in the wards in making up the beds?

DR. BABCOCK: It will pick up pieces of gauze not larger than 1 1-2 inches in diameter, and will pick up lint readily. It has a coarse screen and a large screen, and these accumulations of gauze and lint are held on the large screen, which is pulled out like the drawer of a bureau, and can be readily cleaned at any time.

A MEMBER: I would like to ask if you can clean the wire enclosing elevator shafts. I understand it is necessary to place the brush immediately on the surface to be cleaned. We all know that all elevators are enclosed in a wire cage, which is a very hard place to get at.

DR. BABCOCK: I do not know that we have attempted to clean our elevator shaft with the brush attachment. We have cleaned the wood ledges around the shaft with the attachment, but the wire screens I think we clean otherwise.

A MEMBER: One manufacturer informed us that it was necessary to blow the dust out of the elevator, and then clean the surface around it.

DR. BABCOCK: I see no reason why this machine should not clean the wire screen around the elevator shaft by the vacuum process, without blowing.

MR. BORDEN, Fall River: One thing in connection with our vacuum system which might prove of interest is that in the outlets there were no valves put in. We plugged the outlets. When the vacuum system is running, and you lift up that cap, there is a sudden spurt of air which makes quite a little noise and sometimes startles nervous patients. I think it is advisable to put valves in all outlets in the neighborhood of wards, so that the air can be turned into the hose pipe without the sudden noise made by connecting the house pipe with the outlet.

MR. STRASSER, New York: We installed a vacuum cleaner, and we clean with it everything in the building—the elevator shaft as well as mattresses, robes, etc. I think that the vacuum cleaner for extraordinary cleaning is a great success, while for ordinary cleaning it is not a great success. Too much time is taken up by the labor, but whatever is cleaned is cleaned thoroughly. Our vacuum cleaner is used once a week. I can assure you that whether it is a portable or stationary machine, you will find it a very great labor saver.

DR. MANN, Boston: When we put our machine in I think we were able to reduce our ward maids three in number. Then we hired these two men, and a ward that would take a maid forty-five minutes, the boy can sweep with the vacuum cleaner in twenty minutes. We also figure that we can save a little labor on it.

DR. HURD, Baltimore: If there is nothing else, I will read another question:

Question 2. *"Is it customary for the superintendent of the hospital to attend the monthly board meetings?"*

DR. HURD: In many instances, the superintendent is not expected to be present at the meetings of the board. I know quite a number of institutions where the meetings of the board are held at a distance from the hospital, and it is

not customary for the superintendent to be present. In many instances the superintendent hears of the action proposed about some plan without ever having had an opportunity of stating his side of the case or making any representation on his own part. I should be glad to have some one speak who is permitted to attend the meetings of the board.

MISS LUCIA A. JAQUITH, Worcester, Mass: I attend the board meetings, and was never put out in my life, except to have my salary raised.

MR. BRIGGS, Boston: The board of trustees under whom I work believe it is bad business to have the superintendent present at a meeting, but they always wish me in an adjoining room when I can be called in at any time when they wish to speak to me, or for discussion. I think business men, looking at it from the business point of view, which is the way I look at it, solely, do not consider it advisable to have the superintendent in attendance during a meeting. It stifles free discussion of the complaints going on in hospitals, and many a trustee who might want to say something is not inclined to make any trouble or pass any unkind criticism, and is prevented from taking a part in the discussion. I do not believe it is good business to have the superintendent, as a habit, attending meetings all the time.

A MEMBER: I want to disagree with my friend from Boston. I think it is a good plan. When the superintendent attends the board meetings, and there occurs criticism of anything, he is there to meet it, and to answer, and he is also in position to tell the trustees what should be done. They are good men, but they do not know the interior workings of the institution; he is there to set them right and explain points, and I think it is a mistake when the superintendent does not attend the meetings of the board.

A MEMBER: It is very seldom that our superintendent does not attend these meetings. There are times when he leaves the room, when he sees the discussion is getting to be private, but it is very seldom, and I think they prefer to have the superintendent present rather than absent.

A MEMBER: I have never been kept out of any meetings of the board of managers, and I may say I think it would be a most unfortunate thing to be prohibited from going to a meeting of the board of managers. I was once asked to leave the room in order to have my salary raised. I may say that managers know very little oftentimes, of what is going on in an institution, and many times they do things most detrimental, simply because they do not know. I think there is no one in so good a position as the superintendent to know what ought to be done. I think always where boards meet separate from the hospital, there is very likely to be something wrong going on, and if the superintendent is there, many times certain men will fail to speak, who should not speak. I believe thoroughly it is much more harmonious, much more successful, and better for the institution every way when the superintendent can meet with the board of managers. There ought to be perfect sympathy between them all. I think they have confidence enough in the superintendent to be ready to listen, and generally to do what he wants to have done. There are not two sides to this question. I should feel, if I was not permitted to go to the meetings, that there was possibly something underhanded going on.

REV. DR. KAVANAGH, Brooklyn: I have been attending the meetings of our board for eight years, and have never found it necessary to go out except in one instance, when they raised my salary, and on that occasion I left myself, without being invited to leave. It happens that to-day is the time for the regular monthly meeting of our board, and they may raise my salary. I mention this to show you the importance of having the superintendent there. They have adjourned the meeting purposely until next week, so the superintendent may be on hand to read his report and to answer all questions that are asked. About the most important part of the meeting, as our board would testify, is when the superintendent reads the report that covers the entire month. He will then usually stand there for ten or fifteen minutes answering all sorts of questions bearing upon everything that has been done in the hospital. If the superintendent is only clerk, and is simply to record

the admission of patients and the discharge of patients and the spending of money and receipts, well and good, but if he is to help guide his board in the work they are doing, I do not see how he can do it unless he is there.

A MEMBER: It seems to me we may learn something in this matter by considering the presidents of our universities and colleges, who are usually appointed by boards of regents or boards of trustees, and when so appointed they are almost invariably members, ex-officio, of those boards. Superintendents of hospital should be members, ex-officio, of the boards.

DR. HURD: The next question relates to private rooms:

Question 3. *"Is it fair for a municipal hospital to provide private rooms for people of moderate incomes, and forbid the surgeon charging the patient for his services, assuming that the surgeon did not send the patient to the hospital as a private case?"*

DR. DREW, Worcester, Mass.: I know that there occasionally is a feeling among the physicians that it is unfair. Patients have applied for admission to the private ward of our hospital, because it is cheaper than to consult the surgeon.

A MEMBER: We have a right to place the patient in a private room or semi-private bed, where the patient is able to pay the hospital, but unable to pay the surgeon's fee; but we have to satisfy ourselves as to that fact. If the person has an income of \$2,000 or \$2,500, certainly there should have to be some very extraordinary circumstances in connection with the case to make it improper for him not to pay a surgeon's fee. Certainly a person with \$2,000 or \$2,500 income, ought, as a rule, not only to compensate the hospital, but to compensate the surgeon as well; but when it comes to the case of a person with an income of \$16, \$18 or \$20 a week, possibly with two or three in the family, the question becomes an entirely different one.

MR. PARKE, Montreal: In our hospital we have private rooms, but the indications are when a person wants a private room he is able to pay the fees, and if, therefore, the

person goes into these private rooms he has got to pay the fee.

DR. HURD: I have another question:

Question 4. *"What do the members of the Association think of a central purchasing agency, as has been proposed in the City of New York?"*

DR. GOLDWATER: We are trying very hard to bring the hospitals of New York City in line. Thus far there does not seem to be very much promise of success. The views of the individual superintendents seem to vary considerably. Some of them seem to think that an organization of that sort is very important. There are others who seem to think that the proposed organization is of very little importance. Those are some of the forces that are working against the conception of the organization. It seems to me that a man to head the movement, whose personality is thoroughly known to all the hospital governors, and who has ability to lead such a movement to success, will be welcomed. Probably there is no opposition at all, but only lack of personal leadership.

DR HURD: I will read another question:

Question 5. *"Has any hospital a good arrangement for windows, summer and winter, and shutters and blinds, so that they can be cleaned easily from the inside, and remain in place all the year round?"*

DR. HURD: I know of no such an institution, and never expect to see one. But I should like to have the question answered if any one has. I suppose the person who has written this question has in mind a certain device recommended for hospital use, where the window can be turned on a pivot on each side of the frame, so that the upper and lower side can be washed, but I do not think it is a feasible thing in a great many of our hospital wards, where we have such very large and very heavy windows. I think where there are very strong winds and where we suffer, as we frequently do in the northern states, from the extremes of cold and heat, it is very difficult indeed to keep the windows

tight, and to have them arranged so that the wards will be comfortable.

MR. STEVENS, Boston: I do not know of any device that is used, but it has just occurred to me, as I was listening, that one of the best devices I have seen is in the Royal Victoria Hospital. There the windows open into a sort of a little vestibule for each window, making it possible to clean both the inside and outside. There are double sashes for the colder weather, and both sashes are used. It also allowed for screens in summer; but most of the hospitals in New England that I have had to do with simply use the sliding sash, and clean in the ordinary way.

DR. HURD: Where the double window exists, it is absolutely impossible to clean the outside of the sash in the winter time. I know of no way by which a double window could have a sash hung on the outside that would be at all tight.

Question 6. *"What are you doing to protect your accident cases from the ambulance chaser?"*

DR. HURD: I take it, hearing no response, that we do not any of us suffer from the ambulance chaser. Personally, we try to keep him away. We do not succeed, and never will succeed, as long as we have shyster lawyers; it is impossible to avoid them. We take pains that our own employes shall not be guilty of giving out information about accident cases. I think the real trouble in many instances is the fact that our own employes are suborned by lawyers and undertakers, and persons who are interested in some way in accidents and deaths in hospitals, and the real way to meet the difficulty is to have your own employes right. If ambulance chasers get in, put them out and get rid of them if you possibly can. If anyone else has a patent method of dealing with them, I am sure we will all be glad to hear.

Question 7. *"Is it practicable to admit men to training schools for nurses in general hospitals, and to employ men pupil nurses instead of orderlies? If so, what are the conditions and the organization necessary for success?"*

DR. HURD: There are a few training schools where men are trained. I should be glad to get the experience of some of

those hospitals having such training schools, or superintendents of nurses in charge of such training schools. I understand that at Bellevue Hospital in New York there is a training school for men. My only experience with that was many years ago. I had occasion to visit Bellevue Hospital when the men were trained by one training school and the women were trained by another; and the wards of the hospital were divided between these two training schools. It seemed to me that that arrangement was favorable; that if men were trained in connection with the hospital the superintendent of the training school could be the same for men as for women. At that time there was a great spirit of criticism. The superintendent of nurses who went about with me complained bitterly of the poor nursing done in the men's wards. There was a good deal of criticism on the part of the men as to the nursing done by the women. I think there should be one head to both training schools, and that women and men should be trained in the same school and should have the same responsibilities. If there is anyone here who can throw light on the subject, I should be glad to hear from them.

I have another question relating to training schools:

Question 8. *"What is the average compensation per term to lecturers and instructors in training schools?" Who can answer that question? How much do you pay your instructors?*

MISS LYDA ANDERSON, Philadelphia: I should like to speak for the Episcopal Hospital Training School, in Philadelphia. There they pay their instructors \$5.00 per lecture. There are no free lectures. The lecturers to the nurses are all paid for their services.

DR. HOWLAND, Boston: We pay one instructor, a woman. She is paid about the same as the assistant superintendent of nurses. We pay \$1,000 a year for the instruction of pupils. We have a man to lecture upon surgical topics and he gives them the surgical side of the training. We have a young medical man give the medical side of the lectures. Each one is paid \$300 a year. We found it was easy to get young men who are very promising to devote a great deal of time for this money. It gave them

somewhat of a prestige to be the lecturer to the training school on surgical or medical subjects. It proved a great success. I think our method gives much better results than would free lectures. When we relied upon the staff to give free lectures, the amount of time they put in preparing those lectures sometimes was very small.

MISS KEITH, Rochester: We do not now pay our lecturers, but formerly we paid the young physician who gave the instruction in anatomy and physiology. We paid \$2 a lesson, which made about \$50 for the course for one class. We also paid \$2 a lesson for instruction in elementary bacteriology. This last year we have engaged a resident instructor, one of the graduates from the Teachers' College. The hospital also maintains a woman teacher to whom we pay a salary. She resides in the hospital and conducts five or six class recitations per week.

DR. HURD: I have another question, which I think is of rather general interest:

Question 9. *"Please give outline of an equitable arrangement regarding fees, fair to the hospital, surgeon and patient?"*

DR. HURD: Most of the hospitals seem to disregard the surgeon, and the question is asked, "How can the rights of all three—the patient, the surgeon and the hospital, be met." I should be glad to hear the experience of those present in the matter.

DR. MANN, Boston: We have a rule at our place that any patient entering a private room shall make arrangements with the surgeon or physician for the payment of a reasonable professional fee. That applied only to patients who apply to the hospital for private rooms. If the surgeon sends a patient into the private room he makes arrangements for the room, and we have nothing to do with that. We have throughout the year a certain number of patients who come, whom the superintendent may, in his discretion, admit to a room without any such arrangement. We do that occasionally. We occasionally admit a few patients, who tell the surgeon they are not in a condition to pay; but usually the patient will say, "I can pay the sur-

geon \$50 or a hundred dollars," and the surgeon accepts whatever they can pay. We make them sign a paper agreeing to pay the surgeon a fee, and then the surgeon has to sign it, in acceptance, to avoid having the patient get a bill for twice the amount from the surgeon. It works very satisfactorily.

DR. ALICE M. SEABROOKE, Philadelphia: In our hospital we have exactly the same arrangement that Mr. Mann speaks of, and find it quite satisfactory.

MR. BACON, Chicago: I believe that there are a great many patients that take a ward bed that are well able to pay physician's or surgeon's fee. For illustration we had a patient, a man, admitted to a ward bed, and along in the afternoon the nurse telephoned to me and said that she had a lot of money belonging to this patient, and would like to have it taken care of. So I sent the cashier up, and the cashier came back and said: "I don't want to take that money. The nurse has spent about three hours counting it, and they have got it all rolled up there, and they don't want to take it." I went up to the patient's ward, and I found he had rolls of bills in the bed, and when I got through counting that money there was about \$6,000. If the superintendent would be very careful in investigating these ward patients, they would find a great many of them that are well able to pay surgeon's and physician's fees, and pay for a private room besides. Therefore, we give our patient's to understand that they have got to pay a physician or surgeon's fee if they are able to do so, and it doesn't matter whether they come into an endowed bed or not. If I find upon proper investigation that a patient is too poor to pay a fee, I simply give the doctor the patient's name, and report of my investigation, and he does the work for nothing.

DR. HURD: As I understand it, you have no free beds. All your beds are endowed or for paying patients. You have no absolutely free beds?

MR. BACON, Chicago: We have endowed beds. Patients are sent in to these endowed beds, but we never refuse a patient whether they have money or not, or whether they have a letter from the donor or not. Any patient that ap-

plies to us for admission we take in, if we have a bed to put them in, whether they have money or not.

Question 10. *"Can any member give us figures to show that the cost of conducting a hospital has been made less where the cost system in each department has been introduced?"*

DR. BROWN, Toronto: My only answer to that question would be the annual report of our hospital, which I hope to send to every member of this convention inside of the next two or three months, and I think we will be able to show, compared with last year, a marked reduction. I think the answer will be found in our report. During the past year our per capita has been running under \$1.40 per day, whereas last year it was over \$1.50.

PRESIDENT: The meeting tonight will consider the report of the special school committee. Copies of this report have been sent to all the members, but extra copies can be found in the secretary's office.

DR. BABCOCK: I should like to have the privilege of replying to that question in reference to the annual report. We printed last year many extra copies, so that we have on hand of the Tenth Annual Report two or three hundred additional copies. Members who desire extra copies for any purpose can get them by applying to the Secretary by mail. Members who desire extra copies of the Training School Report, can have any number if they will send me a mailing list of the names of their training school committees or others. I will be glad to mail copies of that report.

Convention adjourned to meet at 8 P. M.

THURSDAY, SEPTEMBER 23—EVENING SESSION.

The meeting was called to order by the President at 8:10 P. M.

PRESIDENT: The business of this evening's session is the report of the Special Committee on Training Schools, presented by the Secretary, Dr. W. L. Babcock, secretary of the committee, and superintendent of The Grace Hospital, Detroit.

DR. BABCOCK: I shall not attempt to read the full report. My reading will be confined to the text and the general recommendations of the committee, and will not take up time with the curricula or the outline of clinics. You have all had this report in pamphlet form, and are more or less familiar with it. (See page 361.)

FRIDAY, SEPTEMBER 24—MORNING SESSION.

The meeting was called to order by the President at 10:20 o'clock.

PRESIDENT: The first business of the session is the report of the Auditing Committee.

MISS ANDERSON, Boston: The Auditing Committee have examined the books of the Treasurer, checked them with the vouchers and found them correct.

PRESIDENT: The whole committee have seen the books of the Treasurer and found them correct.

The next business will be the report of the Committee on Changes in Constitution and By-laws. Is the committee ready to report?

MR. SYMINGTON, Norwich, Conn.: To amend section one, article six, to read as follows: "*The President shall appoint three active members of the Association as a Publication Committee, one of whom shall be the Secretary of the Association. It shall be the duty of this committee to edit and publish the annual transactions of the Association.*"

Add to section 1, article 4: "*A Committee of three on Legislation.*"

Add to article 4 these sections, as follows: "*The Committee on Legislation shall report annually to the Association on all national and state legislation of interest to hospitals or training schools.*"

A new section to read as follows: "*The Association shall establish and maintain permanent headquarters in which shall be deposited official records of the Association*

and all books, pamphlets, plans, drawings, photographs and data, relating to the planning or administration of hospitals or the conduct of organizations for medical relief as may be acquired by the Association, either by gift or purchase.

To amend section 2, article 3, to read: "*Active members shall be those who at the time of their election are contributors to or officers or members of associations the object of which is the foundation of hospitals or the promotion of the interests of organized medical charities.*"

To change article 1, section 2: "*The Association shall appropriate annually a sum not to exceed \$360 for office rent.*"

To amend section 3, article 3, to read: "*The Secretary shall be in charge of the permanent headquarters of the Association and shall keep the minutes of the meetings and the records of the Association. The Secretary shall furnish to the Committee on Publication within ten days after the adjournment of the regular convention, a correct copy of the proceedings. The Secretary shall be allowed not to exceed the sum of \$900 per annum to defray costs of clerical assistance.*"

PRESIDENT: I will ask the Secretary to read one of the amendments suggested.

SECRETARY: This article proposes to amend section 3, article 3: "*The Secretary shall be in charge of the permanent headquarters of the Association and shall keep the minutes of the meetings. The Secretary shall furnish to the Committee on Publication, within ten days after the adjournment of the regular convention, a correct copy of the proceedings. The Secretary shall be allowed not to exceed the sum of \$900 per annum to defray the cost of clerical assistance.*"

PRESIDENT: You have heard this amendment; what is your pleasure in regard to it?

SECRETARY: I would move that this amendment be laid on the table for further consideration of the convention.

The motion was duly seconded, and carried.

SECRETARY: Article 6, section 1: "*The Association shall establish and maintain permanent headquarters in which shall be deposited official records of the Association, and all books, pamphlets, plans, drawings, photographs, or matter relating to the planning or administration of hospitals or the conduct of organizations for medical relief as may be acquired by the Association, either by gift or purchase.*"

Also as proposed, article 9, section 2: "*The Association shall appropriate annually the sum of not to exceed \$360 for office rent.*"

PRESIDENT: What action will the Association take in regard to these proposed amendments?

DR. GOLDWATER, New York: I introduced the amendments yesterday at the suggestion, and as I understood, with the approval of a group of active members of the Association who were in favor of carrying out the suggestion made, so that a permanent office and bureau of hospital information should be established under the auspices of this Association. After the amendment had been introduced most of those who were in favor of this method of expanding the activities of the Association seemed to think that perhaps the amendment was a little too specific, and that perhaps we were somewhat hasty in proceeding at once to establish this office without some preliminary consideration of the way in which the work of the office was to be done. As I understand the general sentiment of those who suggested the introduction of this amendment, it is that this Association should take some action expressing its approval of the idea of ultimately establishing such an office, not necessarily this year. The safer method of procedure would be to table this amendment for the time being, and then to move the appointment of a committee who will consider ways and means of getting this bureau of information started, say not later than January 1, 1911, and at the same time making it mandatory by resolution of the Association this morning that such a bureau should be established by that time. The time is ripe for a definite expression of opinion, but not a final step.

PRESIDENT: Do you make a motion in regard to this recommendation?

DR. GOLDWATER, New York: I move, as a preliminary, that these amendments be laid on the table.

Dr. Babcock seconded the motion, with was carried.

SECRETARY: The next amendment is to amend section 2, article 3, to read: "*Associate members shall be those who at the time of their election are executive officers next in authority below the superintendent, contributors to, or officers, or members of associations, the object of which is the foundation of hospitals, or the promotion of the interests of organized medical charities.*"

A MEMBER: May I ask what are the privileges of associate members?

SECRETARY: Associate members, according to the by-laws, do not have the power to vote. They attend the conventions and take part in the discussions, but are not privileged to vote for officers of the association or for amendments to the Constitution and By-laws. It is intended, by this amendment to the Constitution, to provide a membership for people who are indirectly associated with hospitals, such as members of hospital building associations; members of state charities associations, state aid associations, etc. We have had two or three gentlemen belonging to associations of this class with us during this meeting, and who have taken an active part in our discussions.

MR. BORDEN, Fall River: It occurs to me that there might be some difficulty in the interpretation of the positions of the people who are supposed to be eligible to membership under that new section. One of the most interesting topics of discussion and one which will constantly arise, has been the course of training in the hospitals. The people who are most directly interested in that are the members of what you might call the faculties or teaching forces of the hospital. That includes in a great many hospitals the dietitian, the housekeeper and certain members of the medical staff. Neither of those are next in authority to the superintendent, but they have a great source of information and are vitally interested in administrative subjects concerning the hospitals. It does not seem to me that any harm could be done by admitting those people who have such a vital interest, as associate members. It occurred to me that

if all members of the teaching staff of the hospital were admitted as associate members it might be valuable to the institution and might awaken an interest in the work of the hospital that would go farther than it goes now. I should say do not stop at assistant superintendents; the house-keeper herself may have knowledge of things which the superintendent does not know about, and which she could tell about if we could induce her to come. I do not know whether it is proper at this time to suggest an amendment that members of teaching staffs of hospitals shall be eligible to associate membership or not.

PRESIDENT: I think it is too late at this time. Are there any further remarks?

SECRETARY: We are about to vote on the amendment to section 2, article 3, which will enlarge the scope of associate membership. Under the present by-laws associate members now are limited to executive officers of hospitals next in authority below the superintendent.

The amendment was put to a rising vote, and carried.

PRESIDENT: The Secretary will read another amendment.

SECRETARY: Add to section 1, article 4: "*A committee of three on legislation.* Add to article 4 a new section, section 8: "*A committee on legislation who shall report annually to the Association on all national and state legislation of interest to hospitals or training schools.*"

PRESIDENT: You have heard this recommendation. What do you wish to do with it?

MR. BORDEN, Fall River: It seems to me that it would be very desirable to refer these matters, as the other matters with regard to changes in the constitution, to a committee. In the state of Massachusetts we have something over a thousand bills introduced each year. The only way of determining whether some of those bills before the legislature interest hospitals is to look over the list and examine farther than the titles, and find out what the legislature is attempting to do or has done in regard to matters before them. This amendment, which has been offered makes it mandatory upon that committee to report to this Association

each year whatever has been done throughout the United States of America. You are putting quite a task upon them, if you ask that. You are also putting quite a task upon the Association if they report in accordance with this amendment. It seems to me that while the legislative committee would be very important, the function of that legislative committee ought to be defined more accurately than has been done in this suggested amendment..

DR. GOLDWATER, New York: I agree with what Mr. Borden has said about the wide scope of such a committee, supposing it undertakes its burdens seriously. It seems to me that after we have got our bureau of information, that bureau of information, with its staff, will be in position to perform a large part of the work which such a committee as this would need as a basis of its report. I think it would be very well to postpone the establishment of this committee until the bureau of information is in working order. If it is in order, I would move to lay this amendment on the table.

The motion was duly seconded, put and carried.

SECRETARY: Amend section 1, article 6, to read as follows: "*The President shall appoint three active members of the Association, as a publication committee, one of whom shall be the secretary of the Association. It shall be the duty of this committee to edit and publish annually the transactions of the Association.*" I might say, in reference to amendment, proposed that this publication committee, as it stands in the Constitution, has not acted as such. The Secretary has always done all the work in publishing the transactions, and this new amendment is proposed in order to give the Secretary some assistance in the editing of the transactions.

REV. DR. KAVANAGH, Brooklyn: I move the adoption of this article.

The motion was duly seconded.

MR. BORDEN, Fall River: This is another amendment which is directly correlated with the original suggestion of the establishment of a permanent secretaryship. All these things ought to be considered, by the committee, which I understand it is the intention of this Association to appoint. All these amendments, as I understand it, are so

mixed in with each other and depend so much upon each other, they might all be most reasonably submitted to that same committee for report next year. If you want a publication committee to assist the Secretary this year appoint that publication committee, as we have full authority to do, without meddling with the constitution and by-laws at this time.

PRESIDENT: I think it is very important that the Secretary have help this year, as well as next year. I quite agree with Mr. Borden in the view that we ought not to change our constitution and by-laws too often, but I think we ought to give the Secretary help.

MR. BORDEN, Fall River: That is quite right, sir, but I think it is quite possible to help the Secretary without invoking the constitution.

REV. DR. KAVANAGH, Brooklyn: I think we all agree with Mr. Borden. I think we also agree that the Secretary should have assistance. This question was before us last year in one form or another, and we thought that something should be done. I rather think that this amendment is the result of the mature thought of the Secretary and others with him, and therefore I am strongly in favor of adopting this amendment now. I do not think it at all interferes with the other plans. I move the adoption of this article.

MR. ROBERTSON, Toronto: What would be the duties of this publication committee?

PRESIDENT: To publish the transactions and whatever other printing comes in hand. The Secretary will read the amendment.

SECRETARY: *"It shall be the duty of this committee to edit and publish the annual transactions of the association."*

In reply to Mr. Borden, I might say that if a permanent secretaryship is established in January, 1911, as proposed by Dr. Goldwater, it will be necessary to quite thoroughly revise that section of the constitution that relates to the duties of officers. It will be just as easy to revise it then fully with this change in that section as it would without the change. There will be no additional work involved in the revision, and this would in the meantime assist very

materially in the work of the secretary in publishing the transactions this year. The secretary spent two or three months last year in editing and publishing the transactions. That was a great deal of work. I do not think any of you fully appreciate the work necessary to properly place these transactions before the members.

The motion was put and carried.

PRESIDENT: We will now proceed to the regular business of the morning session.

DR. GOLDWATER, New York: I wish to offer the following amendment to Dr. Kavanagh's motion:

"Resolved that on or before January 1, 1911, a permanent office and bureau of information be established by this Association."

"Resolved that the President appoint a Committee of five members to consider the method of establishing such an office and bureau and of organizing its work, said Committee to report at the next meeting of the Association."

SECRETARY: I would like to propose an amendment to Dr. Goldwater's amendment, that the committee consist of three members instead of five.

PRESIDENT: You have heard all of these amendments that the President does not remember.

REV. DR. KAVANAGH, Brooklyn: I would like the privilege of seconding Dr. Goldwater's substitute.

PRESIDENT: Will you accept all these amendments?

DR. GOLDWATER, New York: Yes, sir.

SECRETARY: The motion is on this amendment: *"Resolved that on or before January 1, 1911, a permanent office and bureau of hospital information be established by this association."*

"Resolved that the president appoint a committee of three members to consider the method of establishing such an office and bureau and of organizing its work, said committee to report at the next meeting of this Association."

The motion was duly put and carried.

PRESIDENT: Is there any other business of this nature to be brought up? If not, we will listen to the reading of

the reports of committees. The first on the program is by Dr. John A. Hornsby, superintendent, Michael Reese Hospital, Chicago. A report of "Committee on the Development of the Association." Dr. Hornsby is not here and so far as we know, has not sent a report. Dr. Ross, of the Buffalo General Hospital, will present the report of the Committee on Hospital Progress. (See page 411.)

The next is the report of the Committee on "Medical Organization, Medical Education and Hospital Progress." The paper will be presented by Dr. Rupert Norton, of Johns Hopkins Hospital, Baltimore, Md. (See page 401.)

PRESIDENT: The next report on the program is by Miss Banfield on Dispensary and Polyclinic Work. Miss Banfield is not here. The next report will be that on Uniform Accounting, written by the Rev. George F. Clover, superintendent, St. Luke's Hospital, New York City. Mr. Clover is unable to come because of illness, and Dr. C. H. Young, Presbyterian Hospital, New York, has kindly consented to read his report. (See page 426.)

DR. HOWARD: We have forgotten to make any appropriation for the committee to report on the Training of Nurse Assistants, etc. I move that the committee be allowed to expend a sum not exceeding three hundred dollars.

The motion was put and carried.

MR. BRIGGS, Boston: Mr. Chairman, you appointed a committee to consider the publication of a handbook by the association.

The Committee, appointed by the President to consider the question relating to the publication of a Hospital Handbook, to be edited by Miss Aikens, report as follows:

The Committee are impressed with the generous spirit and interest shown by Miss Aikens, but it is decided by us, after due consideration, that it is inexpedient for the American Hospital Association to officially endorse or supervise the publication of a handbook for the use of hospital officials. We recommend that no action be taken.

G. LORING BRIGGS,
MARY L. KEITH,
THOMAS HOWELL.

PRESIDENT: You have heard the report of the Committee. What is the pleasure of the Association?

MEMBER: I move that the report be adopted.

The motion was put and carried.

PRESIDENT: We will now listen to the report of the Committee on time and place of the next conference. Mr. Bacon.

MR. BACON, Chicago: Your Committee on Time and Place of Meeting have received invitations from St. Paul, St. Louis and other cities, and after going over the matter carefully have decided, for the welfare of the Association and western hospitals, that we recommend St. Louis, Missouri, and the time to be the third week in September, 1910.

MR. STRASSER, New York: I think it would be wise to make this convention a little later. I know personally several of the superintendents who could not come on account of the early date. Another thing is that the Jewish holidays generally fall on those dates, and I think that should be taken into consideration. It is quite a hardship for some of us who represent Jewish hospitals to be here. There is a Jewish holiday starts tonight and I ought to be home. I think this ought to be taken into consideration, and therefore I would suggest that the meeting should be postponed until October.

DR. HOWARD, Boston: I think that comes under the head of "Traveling in Egypt." When we were traveling in Egypt the suggestion was made that we not travel on a certain day because it was the Sabbath, and when they found out that the Egyptians had one Sunday and the people that we were traveling with had another Sunday, the officers, etc., had a third Sunday, they finally decided it would be best to disregard them all. If we change the meeting of this institution because it falls upon the holidays of the Hebrews, I think that we would have to change it because it will fall upon the holidays of some of the rest of us. I do not think this Association should mind anything about holidays or special sect. While I respect everybody's holidays, I do not think this Association can turn out for anyone.

MEMBER: I think the third week in September is too warm a season for St. Louis, irrespective of holidays.

MR. STRASSER, New York: Our last meeting in Toronto was in October.

REV. DR. KAVANAGH, Brooklyn: I do not think we can afford to ignore the point made by our friend here on the left. It is true that we do not recognize any denominations as such, or any holidays as such, but if anybody or any number of us, should rise up here and say that they have certain feast days and conscientiously observe any particular week, I think we ought to give careful consideration to the matter. If a week later would be more acceptable to our Hebrew brethren, I think we are in duty bound to consider the point which is raised. I would like to make a motion—that the last week in September—be the week for our conference. I have no special reason for saying the last week in September, or the last week in October. I make the motion simply for the sake of bringing it before the body, with only the desire of meeting the point that is raised.

SECRETARY: Last year we met the first week in October, owing to the fact that we could not get accommodations in Toronto the third week in September. I want to say that possibly one-third or more of the hospitals end their hospital year on September 30th. Those that do so are busy with their reports during the first week of October. With me, at least, it would be impossible to attend, and I am sure that is true of a great many. I would like to ask Dr. Kavanagh if he considered that point.

REV. DR. KAVANAGH: I withdraw my motion. I only wanted to start the ball rolling. I think, however, you will find our hospitals very busy at the time when the year closes. It would be a very serious thing. Therefore, I withdraw the motion pertaining to the last week.

MR. STRASSER: May I ask the date of the last meeting in Toronto?

SECRETARY: September 29th, 30th, October 1st, 2nd, 1909.

MR. STRASSER: Could you tell us officially the record of how many delegates attended that meeting, and give us a report of how many less attended this meeting?

PRESIDENT: About an even number.

MR. STRASSER: That would prove that the meeting in Toronto, which was later than this one, was just as well attended, so the objection that other people would not be able to attend that day would fail.

MR. BORDEN, Free River: I am asked by some of the lady superintendents to say that their class work in a great many hospitals begins about the first of October, and that it would be a serious inconvenience for them to interrupt their class work by any later session. I suppose a hospital in spite of holidays, keeps on the work of attending to the school, and I suppose also that most of the superintendents who are here consider that they are just as actively engaged in the work of attending and caring for the sick as they would be at home. While I do not know what conditions exist with regard to religious observances, it seems to me that the observance of this meeting here would interfere no more with the religious observances than the work which is carried on in the hospital. I therefore move that the report of the committee be adopted and that the meeting be held in St. Louis at the time suggested by the committee.

The motion was put and carried.

PRESIDENT: The next business is the report of the nominating committee.

To the American Hospital Association:

The nominating committee presents the following: For President, Dr. H. B. Howard, Peter Brigham Hospital, Boston; First Vice-President, Dr. J. N. E. Brown, Toronto General Hospital, Toronto, Canada; Second Vice-President, Dr. Wayne Smith, Washington University Hospital and Dispensary, St. Louis, Missouri; Third Vice-President, Miss Mary L. Keith, Rochester City Hospital, Rochester, N. Y.; Secretary, Dr. W. L. Babcock, The Grace Hospital, Detroit, Mich.; Treasurer, Mr. Asa Bacon, Presbyterian Hospital, Chicago, Illinois.

Signed,

ROBERT J. WILSON,
LOUISE C. BRENT.

REV. DR. KAVANAGH: I move that the President cast the ballot of this society for these nominees.

The motion was put and carried.

PRESIDENT: I want to take just a moment at this time to extend my appreciation to the members of the Association in general and to a great many in particular, for the work that they have done for the success of this year's session. It was not an easy matter for me to get material together for our meetings, and I wish to express my appreciation to the people who have taken the time and trouble to present papers and to take part in the discussion here. It has meant a great deal of work for a great many people. All of us, especially the people who are in office, know of the work that our Secretary has been doing for this Association. To me personally he has been of the very greatest assistance. I could not possibly have done the work that I did, and the work of the Association could not have been done without his help. The Treasurer, deserves our commendation and appreciation. There is a great deal of work connected with the duties of that office. He is a mighty factor in this Association, and he has done his work well during the past year. My work is done, and I beg to thank you again for your courtesies.

I would like to introduce Dr. Howard. Dr Goldwater, will you lead the president-elect to the chair.

DR. HOWARD: Ladies and Gentlemen, I thank you for the honor that this election implies. I shall do my best to fulfill the duties of the office. Not long after Dr. Peters became President of the Association he made a pilgrimage to Boston, and expressed his feelings that there was one thing that the President always had had to do that was entirely unnecessary and could be omitted from the proceedings of the Association. That was the opening address of the President. Some of us told him that we agreed with him, but that he was not in a position at that time to have an unbiased opinion on the subject. He is in that position, now, and I await any motion from the gentleman to have the opening address at the next session omitted. He had definite convictions upon that subject several months ago, and I think that a man who as a rule carries out his convictions as Dr. Peters does should now proceed to take the first step. I can assure you that I will consider the motion and will be glad to put it.

DR. PETERS, Providence: I should be very glad to make that motion to get the sense of the meeting. From my own standpoint I am not a writer or a speaker, and the question of this address has been a nightmare to me for a good many months. In order to help you and your successor also, I will make a motion that the President's address be omitted.

A MEMBER: It has not been seconded yet.

PRESIDENT HOWARD: I understand that. I want to say personally, although you may have thought I was joking about it, that I believe the doctor is quite right. We are not orators. I was not here at the doctor's address, and I do not doubt but that he gave a good one. But it is a nightmare to a man who is not in the habit of making public addresses to seriously contemplate that he has got to open the meeting of the coming year with an address that should seriously take the attention of the audience. I believe—and I did believe with the doctor, when he talked about it several months ago, that the President's address is something that could reasonably be omitted. I understand Dr. Kavanagh seconds the motion. Now the question is open for discussion.

REV. DR. KAVANAGH, Brooklyn: I want to correct the President at the very outset. If he understands that I have seconded that motion, either my head is not clear or his is wrong, I am not sure which. That motion has not been seconded, and if it had been I would have moved to lay it on the table.

PRESIDENT HOWARD: I think there is no further business to come before the meeting and we stand adjourned until—

A MEMBER: I move that a vote of thanks be extended by the members of this Association to the retiring officers for the year 1908, and 1909.

PRESIDENT HOWARD: You hear the motion. I want to rule that a second motion is no longer necessary. All in favor of that motion will please manifest it by rising. It is unanimously carried. I await a motion for adjournment.

The Convention adjourned at 11:50 A. M. to meet in St. Louis, September 20, 21, 22 and 23, 1910.

PRESIDENT'S ADDRESS.

J. M. PETERS, M. D., PROVIDENCE, R. I.

It has been customary for the president of the Association to present an annual address. I have thought many times during the year of this custom and have expressed to several of our good members my opinion of the uselessness of this duty. However, for the sole purpose of keeping up the habit, and not with any idea of bringing to your attention anything that is startling, new or original, I am here to get off my mind a few thoughts that have come to me.

The growth and developments of hospitals within the past fifty years has been phenomenal, and today questions of construction, development, maintenance and administration are of great importance and require specialists to handle them.

I know of but few lines of work requiring such knowledge in so many branches, such tact in meeting the many people with whom one comes in contact and such patience in meeting the many demands, many unreasonable, that are made by so many people, as does the position of administrator of an institution caring for the acute sick.

As I have come to know better the work of many hospitals, I feel that the demands made on the executive of a small, poor, struggling institution are far greater than those made on one in charge of a large institution where plenty of assistance, personal as well as financial, are available.

Truly, to me, the work of a woman in sole charge of a small, isolated hospital, financially poor and so situated as to be obliged to meet all emergencies at all times, is as grand a one as that of a poor, isolated missionary giving up her whole life and all of her interests for the benefit of others. The strain, the anxiety, the demands upon her time, her patience, her very strength, are far beyond those made upon one in charge of a large institution, so situated and equipped, financially and materially, as to enable the one in

charge to have assistance and to be relieved of the many petty details that take up so much of one's time and strength. All honor to the woman who successfully performs the duties of such a position!

The attitude of the public towards hospitals is altogether different from what it was forty or fifty years ago. Then, they were looked upon as the refuge, the place of the last resort, for the poor and the afflicted. Then, only those applied for admission who were compelled to do so; now they are eagerly sought not only by those unable to pay for medical and nursing services, but also by those well able financially to pay for whatever such care and attention cost.

The growth of treating patients in private rooms at a rate covering at least the cost of such care, has been very marked, and the accommodations now afforded in many hospitals are equal to those of any first-class hotel. Today this work is recognized and carried on, on the lines of a business proposition; it serves those of the community who recognize the benefits to be derived from treatment in an institution and who are able and willing to pay for such care, but who should be expected in a degree to pay an extra amount for such care so as to enable an institution to better care for a larger number of poor patients.

There is no question in my mind that the treatment of private patients is of benefit to hospitals, not only because of the revenue derived therefrom in a direct way, but again because of the indirect benefit derived by an institution by bringing it in direct contact with that class of the community that will get a personal knowledge of it and later assist it directly and indirectly. If an institution is large enough and can attract enough of such private patients to warrant a separate building, I think that it would be best for all concerned to have such patients separated entirely from the ward patients not only for the sake of securing seclusion of such private patients, but also for the purpose of minimizing the friction and the awkward situations that arise (as regards diet, visiting privileges, etc.) when the two classes are treated on the same floor.

The question has often been raised whether it was just to use the money given for charitable purposes, to erect and

equip buildings and to maintain service therein for pay patients. People who give their money for charity naturally object to having that money used in caring for patients who are abundantly able to pay for their own treatment. If it can be shown to these people that such money is expended not only to earn a larger dividend than could be secured through the ordinary investment, but that indirectly it will benefit the institution by bringing in contact with it patients who will not only pay for the cost of their care, but who will also to some degree become supporters of the institution directly and annually, and who will become its moral supporters, and thus help it indirectly, then will the objection lose much of its weight. There is no question in my mind but what the status of a hospital in a community depends largely on the feeling that the medical and nursing professions have for such an institution. If they have the knowledge of the work that it is doing, an interest in the work and in its management, if they are shown courtesies and are given privileges, there can be no doubt of the good that they can do in a community in spreading abroad their opinion in the matter. On the contrary, if they are not recognized nor given privileges, it is only natural that their interest in the matter should not be acute.

I believe fully that the reputation of an institution depends on its management and on the quality of the work done—including in these terms the work done by the governing board, the visiting and resident staff and the household management. I believe, also, that the reputation of such an institution can be influenced very materially by the public press and by the attitude of the physicians and nurses who for some cause are not recognized and treated with courtesy, with tact or with consideration.

To my mind one of the most important factors in creating and fostering the good reputation of an institution in the community is the attitude of the local press. Generally speaking, if the members of this important and influential agency are treated with respect; are given what are ordinarily called the courtesies of the press; are given items that are of a public interest, and if items of news asked for are not given and the reasons thereof explained, I think that the treatment accorded to an institution by the press will be

fair and square, and when appealed to for help such assistance will be given freely and generously. As I look at the matter, the press can be of the greatest benefit or can be a detriment or harmful influence, the extent of which cannot easily be gauged. I believe it is mutually beneficial to both the press and the institution to have articles appear describing new buildings, new work, new ambitions and the things desired and needed. In the smaller cities I believe most papers with which institutions hold friendly relations are only too willing for the sake of news and again for the benefit of the institution, to give it plenty of space, to present annually its report of the work done and to make an appeal for certain definite needs. Such agencies reach practically the whole population and its endorsement means much. The financial results may not be immediate or noticeable, but the impression conveyed and made will stick and result in the giving by somebody at some time to that institution.

There are legitimate ways of bringing an institution before the public and keeping the people informed of the work and of its needs, and, to my mind, the quickest and surest way is through the press, not only in giving it items of daily public interest as relating to the emergency work of the place, but also in giving it opportunities of describing in detail the newer fields of work as it relates to development of the plant, broadening of the character of the work, etc. It has been my experience that if you deal fairly with the gentlemen of the press in giving them what is or will be common news in the way of emergency cases, that they will not expect reports of what may be made into reports of sensational news. I believe firmly in publicity of an institution's work and of its needs and requirements. There is no method of reaching the public so quickly, broadly and impressively as through the press. Annual reports, appeals, etc., are necessary and bring results, but added to these agencies, the press through its articles of description of the institution's daily and yearly work, of its needs and hopes will bring at once, and especially in time, if the system is kept up year after year, a financial interest and assistance that will mean much as the years go on. It is much like business advertising, keeping the public informed regularly

of the needs of the institution. It is a question of education. I believe fully that an annual report ought to be a frank statement of the work accomplished during the year and a detailed descriptive statement of what is needed, for what purpose and to what end. I think that a great duty for us is to teach and to show the members of our several communities the work that has been accomplished in our institutions during the year and the greater good that can be done if better and greater facilities were offered.

It has often seemed to the writer, as he has examined hospitals in different parts of the country, that great shortsightedness has been shown in the location of hospital buildings, not only as regards their accessibility to the thickly settled parts of the community, but also as regards their restriction of area. All of us know institutions built up in cities or towns on land that is the most costly and that is not accessible to the poor for whom the institution was founded.

We know of institutions built on sites so restricted that there is no opportunity for future growth unless by the purchase of improved real estate adjacent to it, the price of which immediately enhances as soon as it becomes known that the institution needs it. How much better would it be for a new institution in looking about for a site, to choose one large enough for future growth, in a location from which most of its patients will come and still accessible by means of street car conveyances. One trouble with us is that we do not look ahead far enough. An institution like a hospital once founded, if it is built to meet a real want and if it is ably and honestly conducted, is bound to grow and expand. It is not a thing of a few years, but practically for centuries. Is it not then the part of wisdom in choosing a site to do so with the future in mind—to buy too much land rather than too little?

As our taste in architecture and esthetics grows, we shall probably build institutions with better taste—fewer flaws in architectural lines—fewer towers and pinnacles—fewer nightmares of sloping roofs, bay-windows, ornaments and passing fancies of ornamentation. What is better, more imposing and more fitting than the simple design of brick or stone finished in good taste and without the

many frills that destroy the beauty of so many of our public buildings?

One of the most promising signs in this work of ours is the specializing of certain men directly concerned in the construction of buildings. It is but a few years ago that the first architect made it his business to study and develop the problems of hospital and institutional architecture and construction. Now, there are several firms paying special attention to this branch of the work. The advance has been rapid and today we are beginning, in new buildings at least, to get down to the basis of the hospital unit so well described by our former president, Dr. G. H. M. Rowe. In some institutions men, capable and interested, have laid down tentative suggestive schemes for the future growth of their institutions. They think out plans as to location, size and height of new buildings, their relation to others of the same plan and to those of their neighbors so that when the time comes for erecting new buildings the space is there ready and the adjustment and relations of the work of the new building fall in readily with those of the old.

To a hospital worker the interior lay-out or floor plan is the important fact, but to the public at large the exterior, the architectural appearance of a building, means more, and undoubtedly makes impressions that count for or against that institution. The day of mongrel architecture is gone forever, I hope, and that of today of simplicity, of good lines, of symmetry, of modesty, is here to remain. It seems to the writer that not enough thought has been given to the locations of institutions, not only as relating to the service that it can render in a given locality, but also as regards its relation to other hospitals. All of us know of institutions that, because of the short-sightedness displayed in their early history, are entirely unsuitably located either because of their distance from the congested parts of the city or because of their proximity to noise, smoke and the impurities of air in their near neighborhood. How farcical it is to build open verandas leading out of wards within a few feet of the tracks of a railroad freight yard! How senseless it is to locate a new institution near the tracks of an elevated railroad in the center of a busy city! Not enough

thought has been given to these very important factors whose deterrent influence will increase with time.

In regard to construction, it seems to me that buildings put up to care for helpless invalids ought above all others to be made as absolutely fireproof as can any building. The difference in cost between such buildings and the ordinary brick structure with wooden beams and partitions has become very small and it does seem as if in the end, not counting fire risk, that the fireproof building would be cheaper in the way of decreased cost of repairs. The fire risk of an institution is an important matter, and if a building is constructed according to the requirements of the factory mutual fire insurance companies, the decrease in the cost of insurance will in a comparatively short time pay for the cost of meeting their requirements. Their inspection—thorough and periodical—their recommendations coming from experts are worth much more to the well-being of the patients placed under our care and are worth much to the comfort of the superintendent's peace of mind.

In regard to the difference in cost of constructing hospital buildings of the ordinary type of brick exterior and combustible interior, I wrote to two prominent building firms in the East and beg to quote parts of their letters referring to the same:

"Taking the Nurses' Home as a model; with cast iron columns, steel beams, reinforced concrete floors, and finished Terrazzo floors, we estimate that the construction cost from 20 to 22 cents per cubic foot. Of course some hospitals have fancy brick work, while the Nurses' Home is plain work; but the additional two cents per cubic foot would take care of this fancy brick work.

"Considering a building that would be constructed of brick with steel beams, and a wooden under-floor, and a wooden upper floor (finished), with cast iron columns, would be at least 11% saving, in this sort of construction.

"Brick building with hard pine columns, hard pine timbers, wooden under floors, and wooden upper floors, would be a saving of 17%. That is, constructions A and B would be 11% and 17% of a saving, as compared with the cost of a building like the Nurses' Home."

"The building we have used for this comparison is a two-story ward 62'-0 x 44'-0, with one wing 62'-0 x 30'-0 and one wing 57'-0 x 36'-0, making a total area of 13,280 sq. ft. on the two floors.

"The central part (62'-0 x 44'-0) contains the main hall, stairway, nurses' rooms, lavatories, diet kitchen, clothing rooms, etc., and the wings are used entirely for wards.

"With the exception of the floors, roof, and windows, the buildings in each case are similar: Concrete foundation; common brick walls; grass course and basement window sills, granite; water table and stone trim above, limestone; plastering, three coats of lime mortar, except baths and lavatories, where Portland and Keene's cement will be used on walls and ceilings; all external and internal angles in plaster walls and ceilings are rounded; iron stairs with slate treads; cornice and all flashing of copper; conductors cast iron.

"In the wood construction the floors have hard pine floor joist, and hard pine top floor; the roof, which is flat, has plank trusses, rafters, boards and a 5-ply tar and gravel roof, and the windows are double hung with wood frame and sash.

"In the fireproof construction the floors and roof are reinforced concrete on steel beams, which are encased in concrete; the top floor is terrazzo; there is a 6" sanitary terrazzo base at all walls, and the windows are galvanized iron frame and sash and may be glazed with wired glass.

"The roof in the fireproof construction is tar and gravel as in wood construction.

"The cost of the building in wood construction would be \$43,000, and in fireproof construction \$54,500, or approximately 27% more.

"The above cost does not include the elevator, heating and ventilating, plumbing, electric work or gas fitting.

"In the wood building these items amounted to \$15,000, and in the fireproof construction would be approximately \$1,000 more."

Is one justified, with these small differences in cost in mind, in erecting any building that is to care for helpless invalids in any other way than that of the best possible

construction for wear and tear and for the safety of those entrusted to his care and protection?

My earnest solicitation, therefore, to those contemplating building an institution is to find the right location for the convenience of the patient, to secure a site large enough for future growth and to build in a simple dignified way buildings that are fireproof and so protected by sprinklers in basements and attics that even the contents cannot burn enough to cause much loss in themselves or to damage and to destroy the buildings or injure or cause possible death to the patients entrusted to our care.

One of the most interesting and promising features of the year's work is the discussion and formation of a group of hospitals in New York City to consider the question of the purchase of hospital supplies by an expert, a paid agent, on whom requisitions will be made for stock in storerooms. The scheme is surely suggestive and undoubtedly will prove practical in the hands of the people interested. The executive heads of all institutions will watch this work with interest and undoubtedly the Association will have a detailed report of the work at a future meeting. The interest and co-operation of such trained and able men in the financial work of institutions are bound to tell in the future work of such places.

The subject of the training of nurses has received much attention during the past few years from both the nursing and the medical professions. The committee appointed by your Association a year ago has considered the matter carefully, impartially and broadly. Its report and recommendations will be presented to you at this session. It is a broad question with many points of contact, and whatever action the Association will take on the committee's recommendation, I bespeak for it your earnest thought and consideration.

The question of the make-up of the registration board of nurses as now constituted in several states is a matter of importance and it is open to question whether it is wisest to place the control of such registration wholly in the hands of the superintendents of training schools and graduate nurses, or whether it would be best to place on such boards, members of the medical staff and superintendents of such

institutions. The training of nurses is a very important factor in the work of an institution, and it would seem that if the training of such women as pupils were part of the supervision of the executives of hospitals, and that if their work as private nurses in after life were done under the direction of medical men, that some executive of a hospital and some medical man connected with a hospital ought to be on the board which would lay down the requirements needed for registration and for governing the work of such nurses in private practice. This organization is made up of representatives of hospitals of all sizes and kinds and from all parts of the United States and Canada, of representatives who as executives have charge or oversight of the training of nurses as one branch of their work. We have appointed a committee to consider the proper requirements for the training of nurses. Would it not be proper to consider carefully this question of representation on such examining boards as are already created or will be created in the future?

There seems to be an utter lack of system, of necessity, even in the establishments of hospitals in certain cities. I know of one city of less than 125,000 population with four hospitals of fair size, and now there is a task of establishing another. It isn't right to the people of that community to ask them to help support any such number of institutions in proportion to the size of the city. The financial burdens of organization, building and maintaining unnecessary institutions seem a crime, and it is unjust to ask a people to found and to maintain and assist financially other institutions, unless there is an actual need of them.

The extra expense of building, equipping and maintaining is not right or just either to the public or to the institutions already in existence, whose whole financial welfare might be ruined by the loss of the support which would be given to the new and unnecessary institutions.

In the May 15, 1909, number of "The Survey," published by the Charity Organization of the City of New York, appears an article entitled "Mr. Rockefeller's Greatest Gift," written by William H. Allen, Director Bureau of Municipal Research, which I commend to the reading of every member of our Association.

The following are excerpts taken bodily from the article:

"Unnecessary charities are seldom abandoned when once the sympathies of the worthy people, however misinformed, are heartily enlisted.

"Every charitable institution should constantly be making an appeal.

"It is highly important that every charitable institution shall have, at all times, the largest possible number of current contributors.

"Local churches, local hospitals, charities, kindergartens and the like, ought not to make appeals outside of the local communities which they serve.

"National and international claims *may properly appeal to men of large means, whose wealth demands their doing something more than assist in caring for local charities.*

"It is not personal interviews and impassioned appeals, but sound and justifying worth that are attracting and securing the funds of philanthropy.

"Generous and adequate support; management by scientific, efficient and able men; *strict accountability of managers not only for the correct financing of funds but for the intelligent and effective use of every penny.*

"One ought not to investigate a single institution by itself, but always in its relation to all similar institutions in that territory, so as not to inaugurate new charities in fields already covered, but rather to strengthen and protect those at work.

"If constant appeals are to be successful, the institution is forced to do efficient work and meet real and manifest needs."

One of the great problems constantly confronting an executive of an institution, is the necessity of doing the work coming to the institution under a fixed income. There are two problems ever in mind—one of controlling the expenditure, the other of increasing the income.

The former (the control of the expenditure) is a difficult one because a large part is in the hands of others—the medical staff, who are practically always in this continent at least, unpaid men working for the benefit they can give to

their fellow men and for the knowledge, the reputation and the indirect benefits accruing to them because of their connection with a given institution.

These men naturally feel, because of the free giving of their knowledge, skill and time, that the institution should furnish whatever in the way of medicines, instruments, appliances and conveniences they should order or think necessary. All of us know of such men who are reasonable in their demands, who recognize that possibly all that the attending men wish to have, it is not practicable for the institution to obtain. Again, there are men on our several staffs who do not recognize that whatever he orders it is not possible to obtain. The relation between the executive and the several members of the staff may be constantly strained because of this and other facts, and one of our duties to the work of the institutions we are connected with is to work in harmony with the members of the staff. To this end, the great needs are tact, patience and self-control. Generally speaking, when there are differences of opinion, the best way of solving the problem is by the coming together of the people interested and the calm discussion of the problem. The mere getting together and the exchange of views or opinions (with self-control always) will straighten out most tangles.

As to the other methods of checking expenditure and controlling waste, it is largely a matter of knowledge gained through experience and from the methods followed by other institutions, which can be learned by visiting and coming in contact with other institutions and their officials.

As to the problem of income—the various methods adapted by institutions ought to be studied and adapted if practicable. One of the most important is the building up of an adequate endowment fund to which all bequests, unless specified, should be credited. Another important source of income is that from receipts for the board and care of patients; there can be no doubt but what this can be increased in many institutions by careful inquiry through the physician of the family, through the tax book and by personal investigation by a paid agent at the home of the applicant.

The annual gifts to an institution, whether by personal or written appeals, by Hospital Saturday and Sunday Associations, by guarantorships, by the receipts from tag or flower day, from theatrical or musical performances, from sales or from any other source, ought to be renewed and repeated year after year in one form or another.

Many hospitals spend every dollar received during the year from any source for paying current expenses and do not increase their capital by such gifts. Would it not be a better way to apply such gifts to the endowment fund and try to run the hospital on a stated capital?

One of the pleasant features of the year's work is the report of a gift (as an appreciation) to one of our members by a friend of the institution with which he is connected.

Some of the older private institutions have begun to follow the custom existing in England of retiring on pensions men who for years have given the best part of their lives to the institution with which they have been connected.

Many hospitals have recently inaugurated an age limit of retirement for members of the staff. This is just and right in most cases as it encourages the younger men who have been doing the work of minor positions, to feel that their chances for promotion are not too remote.

The relations between a hospital and the medical profession in a community ought to be of the friendliest and every courtesy ought to be shown by those in charge of the institution to the members of the medical profession. A readiness to help by the admission of patients recommended by the medical men not connected with the institution; an invitation to be present at the operations performed on the patients recommended by the medical men; an invitation to make the visits in the wards; co-operation with the other institutions and charitable organizations in a community—all tend to help along the work and to establish the position of that institution for readiness to undertake the work for which it was established.

In general terms, a hospital ought to be ready at all times to help other people out of trouble; to gain a reputation of fairness and courtesy. The indirect benefits will

accrue with time, not only in a financial way, but also in the reputation it will gain for trying to do the work for which it was organized.

In the insane asylums many medical assistants are employed, and when a man is needed to fill a higher position, one properly trained is available. How different it is in general hospitals. Until within a few years, there were but few hospitals in the country employing and training men so as to fit them for the position of chief executive in hospital work. Today the situation is changing, and many of the larger places employ one or more assistants who are getting the experience that will fit them to take charge of other institutions. Within a period of a year there were changes of administrative officers in five large institutions in the East. The work is growing—the number of places is increasing and the time has arrived when efforts ought to be made to train men so that they will be able to enter knowingly on the duties of such positions.

The superintendents of nursing have recognized this difficulty and have done wonderful work in creating and developing the Teachers' Institute at Columbia. They deserve great credit for their initiative in bringing this about and for developing and broadening the scope of the work. Some of our members have made a good start in training for executive work, women who wish to enter into the institutional field. The number of places for men is perhaps not large enough to warrant such a step in training men, but there can be no question of the need of it in the near future.

Public institutions are growing in number and in size far beyond the natural increase in the population. They are better built, better organized and better equipped than ever before. The difference between the hospital of today and that built fifty years ago is marked more especially in the way of better construction and simplicity and in the way of better organization.

One of the greatest stimuli to the development of institutional work is that of the magazines whose work is devoted to it. Some of us, who in the earlier years of the work could find nothing in print except the few stray arti-

cles and clippings in medical journals, appreciate fully what stimuli these agencies have been in bringing before us the opinions and the thoughts of others interested in the same line of work. This Association grows stronger in numbers and influence each year. The knowledge that is spread over the country by the papers that are read and the discussions following are of immense importance. The coming together once a year of several hundred people, vitally interested in the same problems and subjects, the giving and the getting assistance from the experience of others, the inspection of institutions in other parts of the country, are all wonderfully beneficial and stimulating.

In bringing to a close these rambling remarks and suggestions, I beg to thank the members of the Association for the courtesy they have shown me and for the assistance they have rendered me during the past year.

Our problems are many, our views of such problems are many, but the mere getting together—the getting of the other fellow's views, the discussion of the many details of our work—not perhaps in the open meeting, but among a few before and after the day's sessions; the meeting of one another engaged in the same work, the visiting of the institutions at the place of meeting—all are valuable and helpful to us and to the work in which we are engaged.

ADMINISTRATION OF MILITARY HOSPITALS.

BY LIEUT.-COL. WILLIAM H. ARTHUR,
Medical Corps, U. S. Army.

When I wrote the secretary of the association telling him I would read a paper on the differences in the administration of military and civil hospitals I forgot for the moment that I do not know anything about the interior management of civil hospitals—and must confine my remarks to military establishments for the care of sick and wounded, leaving you to note the points wherein they differ from civil hospitals.

There are necessarily many points in which the two kinds of establishments must differ.

The medical officer of the army is a part (and we think an important part) of the military establishment, and must take his share of the work of the fighting army. More than any other staff corps the medical is closely associated with the line of the army, and every military expedition whether it is an important scouting party after Indians or an extensive series of military operations, must be accompanied by doctors.

If we were absolutely assured that our country would never be at war again, and that no interior disturbances would arise with which the city and state authorities could not easily cope, the *raison d'être* of the army would disappear and it could be entirely disbanded. But unfortunately the millennium has not yet arrived, and we must keep a force of men prepared to meet emergencies. The duty of taking care of the sick and wounded of this force is an important but a very small part of the medical officer's duty. Probably his most important function is to keep

men out of hospital, but in spite of all sanitary precautions men will get sick, and the soldier's occupation exposes him to injury, and we must keep up a great many small hospitals to care for them when they are unable to do their duty or take care of themselves, and it may be of some interest to you to know something of our methods of managing the hospitals provided for the care of such cases. •

With the army on a peace footing we maintain several different classes of hospitals.

To every garrisoned post is attached a post hospital. It may be a small 12-bed hospital with a garrison of two companies of the coast artillery corps in some small coast-defense fortification or a small cavalry or infantry garrison at some isolated frontier post or a sixty-bed hospital at a post garrisoned by an entire regiment of cavalry, infantry or field artillery or a 150-bed hospital at a brigade post with three or more regiments of different arms in garrison. The post hospital is the typical military hospital in time of peace, and its general management is the duty of a large proportion of the medical officers of the army.

There are at present two general hospitals for the treatment of miscellaneous cases. One for the treatment of tuberculosis only, and one we share with the Navy at Hot Springs, Arkansas, for the treatment of gout, rheumatism and allied diseases.

The large hospital in Manila, in many respects like a general hospital is under control of the division commander through the division chief surgeon and is known as the division hospital.

General hospitals in this country are under the immediate control of the Surgeon-General. That is to say Chief Surgeons of Departments do not exercise any control over them as they do in the case of post hospitals. In the Philippines the Division Chief Surgeon has many of the functions and much of the authority of the Surgeon-General, and in this way bears the same relation to the Division Hospital as the Surgeon-General does to a general hospital, his control of all other hospitals in the Philippines being through chief surgeons of departments.

With the army mobilized and on a war-footing, we have regimental infirmaries and division field hospitals and advance supply depots, with the moving army, rest-station hospitals on the lines of communication, stationary and base hospitals at the base of operations, hospital trains, hospital ships and general hospitals as the final destination of more serious cases. But the time allotted me is short, and I shall confine myself to the consideration of the garrison hospitals and our methods of subsisting and nursing our patients and obtaining supplies, etc.

We have no resident physicians or surgeons and visiting staff—that is, no medical officer actually lives in the hospital, but all are within easy reach by telephone—being quartered in the post, generally as near the hospital as possible, and one medical officer is always on hand. The senior medical officer arranges this and sees that there is no time, night or day, when there is not at least one medical officer available for emergency calls.

The senior medical officer is the superintendent of the hospital, the business manager, the man finally responsible to the commanding officer of the station, to the chief surgeon of the department and to the surgeon general of the army for anything that occurs in his hospital. He may divide the duties among his subordinates, i.e., he may make one of them pathologist, another operating surgeon (generally he does the operating himself) or examiner of recruits, or sanitary inspector, but he cannot transfer his responsibility for property, funds or general administration.

We are fortunate in having intelligent sergeants, first class, formerly known as hospital stewards, who are clerks, druggists, storekeepers and general utility.

NURSING.

Except in some of the general hospitals, we do not employ female nurses. Our nursing is all done by soldiers, men enlisted for the hospital corps, trained as soldiers in the Hospital Corps Schools of instruction, where they graduate after six months' training and are distributed to the various hospitals. These men occasionally develop into excellent nurses, and do admirable work.

During the Spanish War I commanded a hospital ship of 300 beds and we made many trips in West Indian waters and finally by the Suez route to Manila and to San Francisco, and saw many very serious cases, and for the eighteen months the ship was in commission there was never a female nurse aboard on duty. We had a few civilian male trained nurses under contract, selected for me by Dr. Fisher, Superintendent of the Presbyterian Hospital in New York, and I shall always be grateful to him for the care and judgment with which he selected these men, for they proved not only good nurses themselves but helped very much in the training of the raw recruits of which the Hospital Corps detachment on the ship was entirely composed. We had no serious complaints on any of our trips of the nursing.

SUBSISTENCE.

The Hospital Corps detachment at each post hospital, varying in size with the strength of the garrison (and performing many duties besides nursing, e. g., out and indoor police, ambulance drivers, cooks and assistants in operating room, orderlies, etc.), are subsisted like any other soldier on the ration. Any saving made in the ration is sold back to the commissary or the proceeds added to what is called the Hospital Fund. This fund is increased from various sources:

First. Every enlisted patient admitted to hospital stops drawing rations and a per diem allowance of 30 cents is made, and paid by the commissary at the end of each month while he remains in hospital.

Second. Officers and civilians not connected with the service pay \$1.00 a day into the hospital fund.

Third. Civilian employees and retired enlisted men pay 40 cents a day.

Fourth. The hospital may keep cows and chickens, purchased from the hospital fund, and sell milk and eggs, etc., if there are any to spare.

Fifth. Dividends are declared at short intervals by the post baker and post exchange, and the hospital receives its share.

The fund is expended only for extra articles of diet delicacies for the sick, etc., and payment of assistant cooks. A strict account of it is kept and a statement rendered monthly on specially prepared forms.

At large hospitals the fund accumulates rapidly and is ample. At smaller establishments it is occasionally hard to make both ends meet, or at all events the mess cannot be kept up to the standard we should like. It is within the authority of the chief surgeon of a department to order the transfer of funds from a larger and more advantageously situated hospital to one whose hospital fund is reaching the vanishing point.

In many posts a hospital garden is kept up—a cow and chickens and pigs may be kept.

At the general hospitals where female nurses of the Army Nurse Corps are employed an allowance of 30 cents per woman per day is made exactly as per enlisted patients.

COOKING.

Our cooks in ordinary garrison hospitals are soldiers of the Hospital Corps detachment. One cook is regularly rated as an "acting cook" on the muster rolls and paid without expense to the hospital. Assistant cooks must be paid from the hospital fund in addition to their regular pay on the pay-rolls at the rate of \$3.00 a month. The commissary department keeps up schools of cooks and bakers for the entire army, and our cooks are generally graduates of one of these schools.

SUPPLIES.

Our hospitals are liberally supplied these days with all the necessary medicines, hospital stores, instruments, dressing, furniture, bedding, books, etc., required in hospitals of this type.

These supplies are obtained on requisition. The regular annual requisitions for articles on the general supply table in quantities allowed for posts of different sizes go in January 1st. Special requisitions are sent in at irregular intervals. Both kinds are revised by the chief surgeon of

a department who may approve regular requisitions and send direct to the nearest supply depot to be filled, but special requisitions must be approved by the Surgeon General, as well as the chief surgeon, before the supply officer can issue them. In emergency cases purchases may be made and the bills will finally be settled in the Surgeon General's Office. Ordinarily all purchases are made by officers detailed as supply officers. We keep up supply depots at New York, St. Louis, San Francisco and Manila, and a field supply depot here in Washington, where are being accumulated supplies for field hospitals as fast and as in a great a quantity as the appropriations will allow—hoping never again to be caught in the predicament the Spanish War found us in—practically without any supplies for the field, through no fault, however, of the Medical Department. Property received on requisition is taken up on the returns of the senior surgeon, who remains responsible and accountable for it and renders annual returns. As it becomes unserviceable, he disposes of it by action of a survey or by placing it on an inventory and inspection report, and in isolated cases drops it on his own certificate subject to the approval of the Surgeon General. Expendable supplies are simply dropped under the heading “expended with the sick.”

CONSTRUCTION AND REPAIR.

Construction and repair hospitals are provided for each year by a special appropriation, the allotment of funds being left to the Surgeon General.

The senior medical officer decides what repairs his hospital needs, consults the post quartermaster, who estimates the cost of labor and material, and a report, including this estimate, is sent to the Surgeon General every year on the first of March. This date is selected so that all estimates may be considered, and, if approved, the work commenced before the beginning of the next fiscal year, July 1st. As the work goes on the surgeon reports progress monthly to the Surgeon General through the chief surgeon in general hospitals direct to the Surgeon General.

Our employees and enlisted patients are paid like other soldiers, on a monthly pay roll by a paymaster. Officers sick in hospital also draw their pay from the paymaster, but on their own vouchers and do not appear on the hospital pay rolls.

Certain men in the detachment are allowed extra duty pay, printers, automobile ambulance drivers, specially skilled mechanics, etc., but this is not a common custom in general hospitals.

The keeping of official records, rendering returns, reports and official correspondence takes a good many clerks and a great deal of time in the larger hospitals.

I have not time even to enumerate and explain the numerous and more or less complicated reports, monthly sent in from a garrison hospital.

As an instructor in this subject at the Army Medical School I take eight months to cover this subject of the paper work of a hospital.

I cannot even scratch the surface of the subject in 20 minutes, and it would not interest you if I could.

THE HOSPITAL FROM THE PATIENT'S POINT OF VIEW.*

BY W. GILMAN THOMPSON, M. D., NEW YORK.

*Professor of Medicine in the Cornell University Medical
College.*

The past decade has witnessed a phenomenal increase in the general discussion of hospital matters, with a salutary tendency toward comparison and co-operation. We read papers upon the relationship of the hospitals to one another, of the Trustees to the Superintendent, of the internes to their superiors (although they rarely acknowledge that any such exists), and the relationship of the Training schools to everything and everybody, but thus far medical literature has not been overburdened with the point of view of the patient. In fact, with the exception of one or two lurid yellow journal articles and one or two purely sentimental ones, I do not recall that the subject has been approached from the standpoint of the person who, after all, is chiefly concerned—the patient.

It should be remembered that the great majority of patients, speaking now only of the very poor, enter the hospital from compulsion, not from choice. Some are carried there while delirious or unconscious, others enter because their homes are impossible when illness is concerned, and not a few because their means have been exhausted in attempting to secure outside relief. Some, of course, are sufficiently intelligent to realize that the most expert treatment of their ills, especially surgical, is for themselves unobtainable elsewhere. Although it is true that the sick poor are entering hospitals in constantly increasing ratio, there probably always will be a large proportion of the ignorant who dread to submit themselves to expected

*Read by Dr. J. B. Howland.

experimentation, and to place their lives in the control of entire strangers. In New York City, for example, during the 15 years from 1890 to 1905 the ratio of the poor who were treated in general hospitals increased 80%, whereas the general population increase for the same period was only 64%. Explanation of this phenomenon is found in the facts that the hospital structures are improving, that the well-to-do now seek hospital relief in the private pavilions, thereby setting an example, and by the activity of the district nurses, who do much to overcome the antipathy of ignorance.

Being induced to enter a hospital, the patient has the moral right to expect certain things. That he may expect the best medical and surgical treatment is a truism, but may he not rightfully expect much more in what may be called "environmental treatment," and consideration for himself as an individual, not a mere unit lost in routine. It is in these latter respects that we are apt to fall far short of the best that easily might be accomplished.

To illustrate this assertion, I know of no more striking example than the wholly irrational typical hospital ward, which is a mere dormitory, and often a noisy one. For, in the same long room are confined some 25 persons with every variety of ailment, all under identical conditions which have no adaptation whatever to their individual needs.

Has not the neurasthenic patient who has gone to the hospital for relief of insomnia, the right to expect that he will not be disturbed by the ravings of a man with delirium tremens on one side of his bed and the stertorous noisy breathing of the moribund hemiplegic on the other? Has not the patient with pneumonia the right to expect that the air which he breathes shall not be polluted with the noxious emanations of the vomitus or alvine discharges of the patient next adjoining? On the first page of every article on the treatment of typhoid fever we teach that absolute mental as well as physical repose is most essential for the best results. We treat our private cases in this manner and even draw the shades if the light hurts the eyes during the headache stage! Whoever draws the shades opposite the typhoid fever patient in the ward? They would be out of line and

the nurses are taught to shun asymmetry! So we place our typhoid fever patient nearest the door, because he requires much attention and is more accessible, and enliven him by a constant stream of passers-by! Half a dozen doctors, four or five nurses in and out all day with periodically 30 or 40 visitors admitted to the ward besides groups of students and various casual interruptions. I recently had some nurses wear pedometers to see how much walking up and down the wards they necessarily do. The day and night record was the same in each case,—four miles. With three nurses in the ward during the day, there are twelve miles of skipping up and down! Reposeful, isn't it? But then there are the convalescents walking about because in most hospitals in this country they have nowhere else to go but home. In the foreign hospitals they build day rooms for convalescents where they can retire from the depressing influences of the ward, move about freely or read or work or play games, or even in the men's day rooms of French and German hospitals in suitable cases smoke a pipe of peace. Did any American architect ever deliberately build into a hospital a place designed expressly for exercise in inclement weather? The strong Irish laborer, convalescing from a fracture which does not impede locomotion, sits all day in a rocking chair with the cheerful sight of the wounded or diseased all around him, while we overfeed him with milk and other constipating foods. Other patients with certain types of heart disease, cirrhosis, etc., need properly regulated exercise as a most essential factor in treatment, and the cures at Nauheim and Karlsbad include it as a matter of course, but when such patients with us are able to walk they may walk home. Do we ever provide a place for a poor old woman with a chronic bronchitis and emphysema to sit and warm her blue toes and be really comfortable as she would draw about her stove in an easy chair at home? Sometimes there is a soulless radiator, but more often she has the exquisite privilege of sitting in a stuffy ward kept at the same temperature day and night and gazing at a hole in the wall far above her head where some humanitarian architect has seen fit to place a hot-air flue! She could not warm her feet if she stood on her

head! Of course she can stay in bed with a hot water bottle, but she cannot breathe comfortably lying down and there is very little progress in that.

How few of our wards are adequately furnished with proper appliances for keeping patients comfortable in bed, sufficient bed rests, food trays, appliances to prevent slipping down, or cranes to grasp to aid a heavy patient in turning himself over, or side boards to prevent a mildly delirious patient from rolling on the floor. It is, of course, easier to handcuff him and let him fight it out. How many hospitals are provided with emergency beds to fit the very tall or very obese, or the water-logged cardio-nephritic patient who can neither lie down or sit up in peace? Some time ago I had for a patient a very corpulent woman who could not turn over in bed without landing on the floor. Of course like everything else in the hospital, the beds were of cast iron, all from the same mould. So when it was desirable for the good soul to turn over, we had to pipe all hands on deck, help her out of bed, turn her about and hoist her about again the other side over. In the same institution another patient's feet stuck out so far beyond the conventional bed that the nurses brushed against them as they walked by. Of course one cannot construct a hospital or even a ward to provide for every emergency and again there are patients who are enlivened by the doings of a full ward and cheered by its activities and bustle, in fact they feel lonesome if a bed is temporarily empty. The point is, that so little intelligent discretion is exercised, so little discrimination in regard to individual needs and so little appreciation of the importance of such matters as *factors in treatment*. Mental excitement in the presence of fever we all know quickens the pulse, overworks the weak heart and raises the temperature. It is a routine question in some wards when there is a sudden elevation in a typhoid fever temperature curve, to ask "is there some complication, or was it only visiting day?" Cold feet, peripheral congestion, more work for the heart, congestion of the bronchi, more bronchitis—a logical sequence, but of course the architect who put the heater half way up the wall never had cold feet.

It is melancholy to see the pictures in the National Hospital Record of the new hospitals that are still being built all over the country without a sign of a balcony, and an impossible roof. How much longer is it going to take to learn the lesson of the "Great White Plague," that fresh pure free-flowing out-door air is not a specific for tuberculosis alone, but acts through increasing the resisting powers of the organism against many forms of disease. We are told that balconies disfigure the building and darken the wards, but aesthetics and medical science are not expected to harmonize, and as for darkening the wards, I would refer any one to the wards of the new Bellevue Hospital with balconies extending partially along all four sides and which are as bright, cheerful wards as I know of. There at least, after more than twenty-five years of hospital experience in different institutions, I am able for the first time to give patients proper environmental treatment and from the patients' point of view it has proved most successful. The window transoms are left always wide open, winter and summer; heating and ventilation are independent systems; there are many rooms off the wards of various sizes adapted for special cases; patients have the range of day rooms, balconies, corridors and roof. At stated times, in suitable cases, those who are up are made to walk in the fresh air at all seasons and practice deep breathing exercises and calisthenics. The balconies which are very broad, do not entirely surround the wards but are interrupted, and the ward windows are grouped with blank spaces between instead of being placed in the conventional manner, at varying intervals, like a match factory. The walls are agreeably tinted and a nurse is not dismissed for lowering a window shade, or attempting otherwise to consider the comfort of the individual.

And this introduces another aspect of the patient's point of view in relation to the quality of nursing he receives. May he not reasonably expect to be treated more as a sick person and less like a "case" by the nurses. So long as one nurse takes his temperature and another gives him his breakfast and a third who does not know what his vagaries of appetite may have been at breakfast, gives him his dinner,

so long will he remain a "case." Our system is all wrong. Too many people fuss over him and his identity and peculiar needs are submerged in the "system." Whereas one nurse should have exclusive charge of him by day, he has four or five. I knew a patient on a private corridor who had 17 in three weeks, so that it got to be a source of diversion to watch the door for a new face to appear. We fuss over patients too much and yet fail to make them really comfortable. "Too ill to be nursed today" has more biting truth in it than the originator of the story thought. We go on taking patients' temperatures every two or three hours often long after there is any real need of it, merely to keep a nice looking temperature chart hanging at the bed head. Has not the poor woman who enters the hospital because for weeks she has not been able to sleep on account of cardiac asthma a right to expect not to be awakened at 4:30 a. m., because that is the hour for the overworked night nurse to begin to put the ward in order, so that the day nurses will not find fault with her for leaving any work over for them? I knew of a parlor-maid who stopped winding an eight-day clock in the middle of the process, because she said she was going to leave and didn't intend to do any of the work of her successor! From the standpoint of the patient a little less dabbling in legislation, a little less running about to international nursing "congresses," and a little more smoothing of the pillow, and all would be well.

To conclude, my plea is for the patient's point of view, which is that although reasonable order and discipline is absolutely essential in an institution with the varied functions of a hospital, he is, nevertheless, entitled to retain his identity as an individual while in our care. The hospital structure should be specially adapted to and maintained for environmental treatment as well for its psychic as its physical benefits and the whole nursing system should be brought back and strictly held to the original Nightingale standard of relief and succor of the individual. The motto proposed for the entrance archway of the Virchow Hospital in Berlin may well be taken to heart for us all: "In treating the disease, do not omit to treat the man."

THE MANY-SIDEDNESS OF HOSPITAL WORK.

BY HOMER FOLKS, ESQ.

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The most suggestive and scientific book on crime published in this country contains an elaborate explanation of the fact that the writer is unable to define crime. The statutes of New York State are full of references to the subject of probation, but a student might read them all without finding a statement of what probation is. Doubtless we might have many profitable meetings of the American Hospital Association without addressing ourselves directly to the question of what a hospital is. What are the present actual purposes of a general hospital? In considering the chairman's kind invitation to present a paper at this conference, this question insisted on recurring to me. I did not find it an easy one to answer. My general conclusion is suggested by the title of this paper; and such thoughts as occurred to me in the process are herein jotted down.

It might be suggested that the natural place to look for a statement of the purposes of a hospital would be its charter or articles of incorporation. An examination of a considerable number of these leaves us (as the Scotchman said of claret) about where we were before. In a large majority of cases we read that certain individuals "are hereby constituted a corporation," and that the object of the corporation is "to establish and maintain a hospital." The object of the hospital is not stated. In the charter granted by His Majesty George III. to the New York Hospital, it is declared to be the Royal will and pleasure, that when the

corporation shall have acquired a proper and convenient piece of ground and sufficient funds, it shall erect a hospital "for the reception and relief of sick and disabled persons." The word relief was happily chosen. If it were intended originally to convey the same suggestion as is conveyed in the famous English poor law—charitable assistance—it nevertheless lends itself readily to that diversified range of beneficent activities which now characterize that and other modern hospitals. The founders of the Massachusetts General Hospital, in a letter addressed to the public by the trustees of the hospital in 1814, declared that "the end of the institution is cure of the disease, whether bodily or mental, under which they (the patients) labor." This appears to have been thought insufficient, for in a later letter, also addressed to the public by the trustees of the hospital, they declare that this charity is intended to alleviate and diminish the amount of human calamity generally." This certainly is sufficiently flexible to permit of adaptation to changing conditions. The Methodist Episcopal Hospital of Brooklyn, according to its formal statement, is to care for the sick, not including contagious diseases," "without regard to color, creed or nationality," "to the glory of God and the relief of humanity." The letter of Mr. Johns Hopkins to the trustees of the hospital which he purposed to establish, contains perhaps the fullest suggestion of objects and purposes found in any documents of this character: The indigent sick of Baltimore and environs who may require surgical or medical treatment, and those who are stricken down by any casualty shall be received into the hospital. A training school for female nurses is also to be established as part of the hospital, and a separate provision for convalescent patients. It is also to be constantly borne in mind that the institution is to form part of the Medical School of Johns Hopkins University.

It is evident that the manifold activities and beneficences of the modern hospital are not foreshadowed in their original declaration of purposes. It is reasonably clear that many of them were not foreseen by the founders, though in some cases, the purposes were made so general and comprehensive, not to say vague, as to include, by fair inter-

pretation, their present activities. This is as it should be. If there is nothing new under the sun, it is equally true that there is nothing old under the sun. Changes in conditions, changes in social ideals, and, above all, increased medical knowledge inevitably affect powerfully the development of hospitals. Some of the earlier lines of work took on additional emphasis, some became of less importance, and some altogether new undertakings were entered upon.

For a truer conception of what the modern hospital is we may look more profitably to the thing itself. Dismissing preconceived ideas and trying to sum up the present actual activities of general hospitals, resulting from their efforts to keep pace, in some degree, with the demands of the community, it appears that at the present time the actual objects and purposes of a general hospital have reached the perfect number of seven, and are:

1. The Care of the Sick.
2. The Cure of the Sick.
3. The Education of the Sick.
4. The Training of Nurses.
5. The Training of Physicians.
6. The Extension of Medical Knowledge.
7. The Prevention of Disease.

Each of these functions may, in my judgment, be properly considered as an established duty of a general hospital. Every question of policy, development, construction, location, organization and staff should be considered with reference to all these purposes. A determination on any one of these points which ignores any of these seven purposes is defective, and marks the entrance upon a branch road, from which the steps must be retraced later on. They are not inconsistent, one with another, in any respect. They exercise a mutual restraint each upon the other, and that limitation is for the good of the patient.

Considering these purposes more in detail, it appears that:

1. The hospital exists, for one thing, for the *care* of the sick. This purpose is a charitable one. It provides food, shelter, clothing, and attention for those who otherwise

would be deprived of these necessities in whole or in part. It relieves overcrowded homes and overworked homekeepers of burdens which otherwise, when added to heavy routine duties, would be intolerable. Hospitals have not, so far as I am aware, been afflicted by that delusion that has attacked schools for the blind and mutes, that because they are educational institutions they are not to be considered as charities. The Court of Appeals of our state has decided that the fact that an institution is educational does not mean that it may not be at the same time charitable, and subject to the laws relating to charities. Many hospitals recognize the fact that they are charitable as they pass the hat annually. In serving their later purposes there is sometimes a temptation to forget this underlying and fundamental one. Resident and attending physicians especially need to be reminded occasionally of the charitable origin, nature, and purpose of hospitals. If none but those who are considered curable are ever admitted; and if those found to be chronic or incurable are discharged on the tick of the watch, regardless of hour, condition or destination, the first purpose of the hospital has been forgotten, and violence has been done to our principle that every administrative act should recognize all of the seven hospital purposes.

2. The hospital exists also for the *cure* of disease. It is an expensive plant, expensively operated. It is equipped to do important work. It should not be burdened permanently with work which a less expensively constructed and operated mechanism could perform equally well. Having exhausted the possibility of cure, it may properly, after an appropriate time, in a humane way, and with careful consideration of the circumstances, condition at the moment, and destination, of the chronic or incurable patient, remove him to some other charitable institution established for his special benefit. The transfer of a certain number of patients to institutions for the more or less permanent care of the bedridden is a necessary feature of the administration of the general hospital, if it is not to do violence to its second purpose,—the cure of disease. Otherwise it would become a hospital for incurables; or erring on the other side, would refuse to admit to its shelter many for whom

there are possibilities, but not certainty, of cure. If transfer is forbidden, admissions are sure to be too sharply scrutinized for the purpose of preventing the admission of those who may prove to be chronic or incurable.

3. Besides caring for and curing patients, each hospital, apart from any conscious purpose so to do, is constantly educating its patients in standards of living. These standards relate to the selection, preparation and serving of food; to housekeeping, particularly in its sanitary aspects; and to all sorts of ethical relations between patient and patient, patient and nurse, and patient and physician. The hospital standard may be better or they may be worse than those to which the patient has been accustomed. In the ranks of organized charity we hear much lately of standards of living and of the supreme importance of raising standards of living where they are low. The hospitals of a great city have a unique opportunity to establish new standards of living on the part of their patients. Every patient should leave the hospital with a better understanding of what sorts of food should be purchased, how the food should be prepared and served, how dust should be removed, how ventilation should be secured, and with higher ideas as to one's duties to his fellowmen. In short, with a much more thorough training in the art of living.

That the state hospitals for the insane in New York have measurably realized this ideal may be gathered from the reports written by the husband of an Italian woman who had been a patient in one of our state hospitals for five months. He was required to report his wife's condition once a week, during the period of parole. In the first and second reports he speaks of many evidences of improvement on his wife's part during her hospital sojourn.

The third and final report included the following:

"It is three weeks now since I took my wife home, and I must say she is doing fine. She wants me to compliment you on your table board. She misses your delicious prunes and apricots or quince for supper, your oatmeal and hominy, I believe it is called cereal, by your beautiful and accomplished nurses. Then again for your Indian red corn meal and syrup or molasses. She misses your baths

very much, standing up under the hose and she learned a whole lot of housekeeping and economy that I never thought I could make her learn. She asked me not to forget to mention your famous L. I. salad, your fresh green lettuce with its new mode of dressing. I can assure you the change has done her good. It reminded her of life in the country when she was a girl. So let me tell you that life in the sanitarium agreed with my wife. To tell you the truth, doctor, she seems to me like a new woman.

Not all relatives and friends have written in similar vein upon the return of patients from hospitals.

4. The *training of nurses* has become a well recognized branch of the work of general hospitals including those under municipal and state auspices. It is a striking fact that the Charities Department of New York City, with no special legal authority except that of caring for the poor, carries on, incidental thereto, and as an economical means of caring for the poor, four very important educational institutions equipped with teachers, classes, class rooms, laboratories and a wide range of educational facilities. In this case the necessities and advantages of the situation have gone far ahead of the statute. Controversies arise occasionally and the voice of reaction is sometimes heard, but in the main the sensible view obtains that in the care of the sick, as in other difficult work, the more thorough the training the better.

5. The *training of physicians* is an actual part of the work of all American hospitals though it is less frequently openly recognized as such than is the training of nurses. The training of physicians is a necessity, not a luxury. All professions must be recruited with new blood. The young lawyer must have his first clients, the young preacher his first charge, the young teacher his first class, and the young doctor his first patients. The young doctor, however, has this great advantage, that if he is fortunate he may care for his first patients under the daily supervision and direction of an older member of the profession. The cheap demagogue may declaim against the use of the hospitals for teaching purposes, but a sober view of the situation must lead anyone to the conclusion that experience as a

hospital interne is a peculiarly happy method of minimizing the number of mistakes on the part of the young practitioner. A word of caution sometimes is in order. It is part of the plan that the visiting physician shall actually direct the work of the interne, not vice versa. If the visits of the visiting physician are so brief and the number of patients under his care so great, that he can only take a look at the more interesting cases and observe their development, leaving the actual treatment in the hands of the interne, violence is done to the plan and reform is in order. The training of physicians is a proper and legitimate function of the hospital, but it must be carried on in a manner consistent with *all* the other purposes of the hospital, including the care and cure of the sick.

6. The hospital has also a most important function to perform in contributing to the development of medical knowledge. This is recognized very fully by some hospitals with their splendidly equipped laboratories, well qualified pathologists, and ample staff of assistants; in some slight degree in others, in which facilities for pathological research are grudgingly given, laboratories are inadequate in capacity and equipment, and salaried force wanting; it is practically disregarded by still other hospitals. I need not recount the important contributions to the development of medical science which have resulted directly from hospital work, nor dwell upon the fact that only in hospitals are opportunities for many lines of research to be found. A traveler taking any one of the boats plying on the East River today observes a modern, fireproof building, apparently constructed, as seems to be their habit, from the top down, at the East River and Sixty-sixth street. It is to be the hospital of the Rockefeller Institute for Medical Research, established simply and solely because, in order to accomplish its purpose of perfecting our knowledge of certain diseases, the agency for so doing must be, among many other things, a hospital. Conclusive evidence, if evidence were needed, that it is part of the duties of every general hospital to make its contribution to the most beneficent of all sciences, the science of medicine.

7. To these six duties, another is being added as we write. A new leaven is entering the medical profession and is disturbing it at many different points. It is the recognition of the opportunity, and opportunity spells duty, of physicians to *prevent* disease, not simply to cure it. I need only call attention to the establishment of the new chair of preventive medicine in the medical school at Harvard, the well defined plan for a similar department at the College of Physicians and Surgeons, which was developed last year to the extent of a series of lectures of extraordinary interest, shortly to appear in book form; a similar course of lectures under the auspices of the State Department of Health at Cornell University; the world wide movement for the prevention of tuberculosis; the adoption by charity organization societies and similar bodies of plans for the prevention of disease as one of the means of preventing poverty; the fact that the most popular articles in the most popular magazines are those dealing with preventing disease, and the movement for a National Bureau of Health. All this evidences a profound reconstruction of the place of the medical profession in the community. These changes will certainly affect not only the medical profession but also all agencies having to do with health work, including hospitals. For this reason I name as last of the functions of a general hospital, one which it is not now performing to a large extent, but which it is taking up already in some degree, that of *preventing disease*. The methods by which this may be done are becoming fairly evident. The agency through which the hospital will perform this function will undoubtedly be its dispensary—that greatest of all wasted opportunities. If dispensaries generally have been characterized by superficial, ineffective medical work, they may be about to realize their true field in linking the hospital in its educational and preventive work with the homes of the community. Through its dispensary the hospital comes in contact with very large numbers of people, many of whom will become candidates for its wards unless they can be given needed lessons in hygiene and sanitation, and unless these lessons be taught not once only, but line upon line and precept upon precept, I look to see many patients

admitted to hospitals, not to cure disease, but to ward it off. I look to see well-trained physicians and nurses, going from dispensaries, into the homes of patients to discover and assist in correcting the conditions which are contributing to physical breakdown. Social service need not be conditioned upon entrance to a hospital. After care is but a step toward ante-care, which is much more easy, wise, and economical. Notwithstanding the present prominence of agencies other than hospitals in preventive work, such as societies, committees, and public officials, I am inclined to think that one of the greatest factors in the revolutionary movement of preventive medicine, will be the general hospital operating through its dispensary. None of its six earlier functions need be dropped or slighted. A change of emphasis here and there, a slightly different point of view, some additions to the staff, and bearing in mind, in settling all questions of administration, the fact that prevention is better than cure.

Truly, the modern hospital is a many sided affair. Its readjustment and development call for synthetic ability of the highest order.

DISCUSSION.

DR. R. W. BRUCE SMITH, TORONTO: After listening to three such papers as we have been favored with tonight, we should certainly have a discussion that will enable each one of us to take home from this meeting lessons that will be remembered. The papers that we have listened to have been full of information. The paper by Col. Arthur gave to myself, and, I believe, to others, new light on the conduct and management of military hospitals. The paper by Dr. Thompson was certainly rich in thought. To how many of us does it come home, that the patient's viewpoint in hospital routine does not receive the consideration and the sympathy that it deserves. The paper that we have had from the last speaker, Mr. Folks, is only one such as we would expect from the gentleman who has taken such an interest, and contributed so much to the work of charities in the State of New York, and whose work is known, I may say, throughout the whole of this continent. There is certainly manifested a large development and a greater

appreciation of hospitals; also a fuller recognition of the many sides that a hospital has in its relation to the community, as well as its relation to the patient. I had hoped that one who is so well able to deal with that subject would have taken up what is, to us in Canada, a very important part of hospital work just now—the relation of the municipality directly to the hospital. Are we right in encouraging, in a new country, the establishment of municipal hospitals instead of voluntary hospitals, that have hitherto so largely prevailed in our country as well as in your own? I am strongly opposed to municipal hospitals. I am a firm believer in the hospital being an institution that should be managed voluntarily, and separate from the municipality, or any other part of the political machinery that may obtain in this or any other country. The sentiment leading toward the introduction of municipal hospitals is a mistake. It is a great mistake to lose sight of the many sides that a hospital must bear to the community: the care of the patient, the cure of the sick, the training of nurses, the training of physicians, the educational functions of the hospital, and the prevention of disease. These facts have been so extensively and so well illustrated and brought out by Mr. Folks that I feel that I cannot add to the paper that he has given us tonight, except to say that I heartily endorse the sentiments he has so well expressed therein.

MISS EMMA ANDERSON, BOSTON: It seems to me that the small hospitals have done a great deal to help meet the objections that are spoken of in that paper. My training was in a large hospital, and one of the best. But it seemed to me that when the patient came to the ward, and looked down that long row of twenty beds, with a pink ticket in her hand, and no nurse had time to greet her, that there was room for a hospital where the patient could be considered a little more in a personal way. I believe that the larger hospitals have benefited from the methods of the smaller hospital, in treating the patient personally.

THE HOSPITAL AND THE PUBLIC.*

BY DEL T. SUTTON, ESQ.
DETROIT, MICH.

Editor International Hospital Record.

Mr. President, Members of the American Hospital Association, and Ladies and Gentlemen: Up to a few days ago I had fully expected to be present at this meeting and address you on the subject of the relationship existing at the present time, and which I believe should exist in the future, between the hospitals and the general public, but health conditions in my family have assumed such a stage that I find it impossible to be present with you. I especially regret this, not only because I had looked forward to this meeting with much pleasure, but because of the fact that I presume that some of the views I shall express will call out opposition, and I would like to hear the criticisms and also have the opportunity to defend my position. In view of my absence I shall simply confine this paper to a few statements regarding the present existing conditions, together with suggestions regarding changes to be made for the general betterment of these conditions.

My position is simply this: As a result of my connection with and study of the hospital field during the past twelve years, I am firm in the belief that the American hospital field and the American public know too little of each other. In view of the fact that during the more than twenty years of my business life prior to the establishment of THE HOSPITAL RECORD my work brought me into close contact with the business and general public, my study of the hospital field has naturally been more from a general business than a professional viewpoint, although I feel that twelve years of study of the hospital field has enabled me to know something of the inner workings and the needs of hospitals. My

*Read by Mr. George Bailey, Jr.

experience has taught me, as have the experiences of every man who has studied general business and economic questions that in order to make a success of any enterprise dependent for its support upon the general public the general public must be thoroughly acquainted with the aims, work and needs of that enterprise. I believe that you will all agree with me in the statement that but a very small percentage of the American people have any definite, intelligent idea of the American hospital field. The people generally know that such institutions as hospitals exist, and that they are for the purpose of caring for the sick and injured; many of them believe that a hospital is a place to keep away from whenever it be possible; some of them believe that the hospital atmosphere is not any too strongly impregnated with human kindness and human sympathy; others believe that hospitals are largely maintained to provide opportunities for the surgeons to indiscriminately wield the knife. It seldom occurs to the individual what a hospital means to a community. Only when a casualty of large proportions startles a community does the fact of a hospital, with all that it means, challenge public attention. But few know or appreciate the fact that the modern hospital is not only the best, but also the cheapest, place in which to receive proper treatment and care during an illness or when a surgical operation is required; but few know or realize that the hospital atmosphere is one of medical and surgical skill, of constant, scientific, sympathetic care and attention; of cleanliness and hygienic surroundings not possible in the private home; that the hospital presents health dietaries not possible in the private home; but few know or realize that to be cared for in a hospital means better and more skillful treatment and increased chance for recovery than in the private home, and all this at less expense, and with the removal from the home of the elements of sickness which go to disrupt the plan of domestic economy.

The questions now arise, who are to blame for this lack of knowledge upon the part of the general public? What have the hospitals done in the past, and what are they doing today to educate the general public regarding the benefits

and needs of hospitals? and, what are they going to do in the future? No one can deny that the American hospital must depend upon the American public for its support. The money with which to purchase the sites, to erect and equip the buildings and to provide for the maintenance, and the patients, must all come from the general public. Without the support of the general public, hospitals can not exist, without the hospitals, the general public can, as it does in many sections or localities, exist after a fashion. The "burden of proof," therefore, rests on the hospitals—the hospitals must offer the needed education to the people, rather than the people seek the information from the hospitals. It is a purely business proposition if we seek the enlargement of hospital work and efficiency. The merchant or the manufacturer who seeks to have the public purchase his wares must acquaint the public with the merits of his wares; the hospital seeking the public support and patronage must acquaint the public with the superiority of its facilities and the advantages to be had from hospital treatment.

No great institution or movement, no great business enterprise ever has or ever will be a success without the hearty co-operation and support of the public generally. The world does not contain an institution greater in material value than its hospital system. As a conservator of public health it occupies a foremost position as an element in the worlds' general welfare. It is an actual working, living component part of the world's people, and should and must work in perfect harmony with all of the other component parts in order that it may make its influence fully felt and produce the greatest possible good.

I shall not advocate the advertising of hospitals in a generally commercial manner, in the public press, because I know that to some this might appear to be unethical, but I would strongly advocate that it is the duty of the American Hospital Association, as a leading factor and influence in the American hospital field, to at once provide for the inauguration and development of a publicity and educational campaign such as will enable the general public to much more thoroughly understand and appreciate the

value of the hospital to the public. There are many benefits to be gained by such a campaign, some of which may be stated as follows:

First—A proper understanding by the public of hospital work would do more than all other influences and efforts combined to remove from the public mind the present aversion to hospitals and the dread of entering a hospital for treatment;

Second—The proper education of the public would prove that it is not only much better but also much cheaper to have its sick and injured cared for in a hospital than in the home;

Third—Possessed of a proper understanding of the work and needs of hospitals, it would be found that the public would be much more willing to contribute to the support of hospitals, not only through direct donations, but also by being willing to pay at least a living rate for the accommodations provided.

The American public of today is not niggardly in its composition. Many decades ago our forefathers dumped the tea into the waters at Boston Harbor because of their objection to what they considered to be unjust taxation. Since that time the world has grown, and the people have also grown and broadened, and today the American people stand ready to properly support and encourage any worthy object. The average American is not only willing, but prefers, to pay a decent living price for whatever he obtains, and I firmly believe that the seeming inability of hospitals to obtain fees such as will at least cover cost is due to the hospitals rather than to the public. There are few who seek to be branded as paupers or semi-paupers. The main reason why hospitals are at the present time receiving but \$7 per week for ward cases and \$20 for private cases is simply because they do not ask more, and not because the public can not or will not pay more. Education along proper lines will largely remedy such evils.

Before the American hospital can come into its own, the public must come to know that the hospital is nothing less than a vital, living force that can not be dispensed with—that it is a needed necessity in every community of size; it

must come to know that it requires money, and lots of it, to erect, equip and operate a hospital; it must come to realize that the laborer is worthy of his hire. All of the various influences should and must be called into action to firmly plant these ideas in the minds of the public.

Every man, woman and child upon birth, or on admission to American soil, becomes an integral part of the general commonwealth, and each should bear his or her share of the burdens and share the responsibilities.

How best to educate the public regarding hospital work and hospital needs may perhaps be something of a problem. It may, however, be said that of all the influences that have co-operated for the advancement of the general welfare none have been more potent or more helpful than the power and influence of the public press, and I believe that it is through this medium that we must most largely direct our efforts. Carefully prepared, interesting articles regarding hospitals and hospital work would, I am certain, be accepted and published by the public press, and it is only in this way that we can reach the public generally. Through this channel we may inoculate the public with the enthusiasm we ourselves possess and by thus throwing on the light bring the public to know and realize its obligation to the hospitals.

The time to start this educational campaign is now, right now, at this meeting of the American Hospital Association. Everything conceivable, organic or inorganic, in the great universe of God, is evolved from a starting point. This campaign should be made a broad, conscious policy of business to educate the public up to a better understanding and a more intimate relationship between our hospitals and the public.

Someone has written that an aggressive fight for the right is the grandest sport the world has ever known. Let's make an aggressive fight for that which is right in the interest of the advancement of the hospital field and its interests.

THE HOSPITAL AND THE PATIENT OF MODERATE MEANS.

BY FREDERICK BRUSH, M. D.,

*Med. Supt. New York Post Graduate Med. School and
Hospital.*

The sick poor are now fairly well provided for; the sick rich command the best; the patient of moderate means, who can pay something, and only so much, fares least well, both as to hospital and private treatment, for even in the latter case, the other classes may more readily get skilled medical attendance, consultation, operation, etc.

It will be granted, probably, that in many cases the hospital offers a better chance of cure or repair than the home. The rich and the poor may promptly enter our hospitals, of one kind or another, when seriously ill; the middle class patient meets frequent and considerable obstacle or delay.

It will be urged that we have no "middle class," but while it is true that no very definite lines may be drawn, we all recognize the broad grouping of the great body of men and women who do daily work for modest wage, whose incomes cease or shrink with illness, and whose savings will carry them but a definite, short way. They are the best of the people, most essential to be kept at high efficiency, most needful of quick restoration to health—the greatest national asset. Over ninety per cent of the population may be so classed; most of us are in the group.

The hospitals were for the poor. They are largely now for the poor and the rich. In time they may be for all. An old question presents. Has the middle class patient, who can for a term pay the family physician, a right to expect hospital treatment in time of stress? In the years of disrupting controversy over "hospital abuse" it has often been

nearly decided that he has not. Is the mechanic of to-day in a fundamental right, who, on learning that his wife must have immediate operation for suppurative appendicitis, says: "I want her taken to a hospital. I believe in them; I believe that's her best chance. What? No place, except in that sanitorium, or possibly in a charity bed? Something is wrong here. I want to pay—something—all I have, and can—you know what that is—but I want her in a hospital. She and the children and I have a right to the best chance, along with the others, haven't we?"

We here know that the answer is yes; that these thousands of wards and rooms must be provided, that hospital building in this country is only well begun, that the money will come, and that it should, to considerable degree, come from the people who are to benefit.

How the so-called "common people" are to be directed into organization and self help in this matter, is one of the larger hospital and social problems. In parts of the West and South the private and semi-private hospitals and sanatoria, providing seven to twenty-five dollar beds are making toward solution, but in the East and in our large cities, the need above outlined is measurable and large.

Instance tuberculosis, where our greatest weakness at present is in just this lack of middle-rate accommodations; for the relatives or friends of a majority of early tuberculous patients will gather and pay seven to fifteen dollars per week for three to six months.

Consciously or not, all concerned in hospital management are daily working out the beginnings of this great extension—hospital provision for our Third Estate. For example, nearly the whole of the seemingly unmitigable hospital abuse trouble develops about the patient with a little money, and a belief in hospitals; and it will not be well cleared until the hospital extends its open recognition to the middle class out and in-patient, and in carefully selected cases takes pay for services fairly rendered.

The collection by the hospital of twenty-five cents for corrective treatments, \$1.00-\$5.00 for X-Ray, \$2 for glasses, cost prices for orthopedic appliances, etc., etc., is recognition of the patients' growing right in the matter, and marks

the beginnings, not only of increasing incomes for hospitals, but of greater, better and more equitable service to the constituent communities.

Desirable now is the establishing of more definite relations between private physician, hospital, patient and hospital physicians.

For illustration: In many of our best hospitals but a short time ago, the X-Ray departments were sources of much trouble and concern. Unconnected physicians sent patients to get pictures free, and fetch the plates, sometimes themselves collecting goodly fees for the adroit management of the affair. Morbid folks got themselves rayed, and made various unfortunate uses of the results. Attached physicians used the institution's apparatus in various ways, unfair to it and to deserving outside specialists. The radiographer ran side lines of business within and without the hospital. Instrument makers were generally intimately involved. Minor hospital employees were corrupted.

Then came free discussions, understandings, rules—X-Ray work done only upon requisition, through office. Set maximum charges for the various procedures. Collections at the office, the patient's financial ability being reasonably investigated, with graduated and free service where deserved.

Free lists for the different classes of in-patients. Accurate, available, valuable records. Salaried radiographer, or arrangements under rule for restricted use of apparatus for his private cases—or both.

Results: Injustices nearly abolished, all ways, with increased incomes to the institution, the family physician and the radiographer, and the patient's satisfaction in evident fair dealing. Best of all, the establishment of co-operation, mutual respect, courtesies, with increased efficiency and scientific output.

Other departments in our institutions today are awaiting like organizations in these matters relating so largely to the part-pay patient.

A chronically acute hospital trouble revolves about this middle class patient and the visiting physician. The physician contends: The patient enters your dispensary and gets

advice free, is admitted to your free or seven-dollar bed, where I attend or operate without compensation, knowing in many cases that the patient is able, even willing to pay fairly for services.

Private patients take my office advice and then enter your institution to pass through similar procedure. New pay-patients, referred and otherwise, seek me at the hospital during my onerous hours there, and under your rules are not permitted to reach me, are even diverted, etc., etc.

The hospital rejoins: You have not co-operated well when we have sought legitimately to investigate cases. You have placed patients in our free or part free beds and collected generous fees for your services, have taken all the patient's savings at your office and then have sent him to us, a heavy burden, instead of arranging and dividing fairly for the good of all. You have placed patients one to three days with us, gotten our expensive and valuable tests and consultations free, then removed them to your private place, etc.

Grades of this state of things are still present, in most hospitals. The condition has been gazed at with smoked glasses, calsomined, circumnavigated, and smothered in word-dressing, to little effect; yet it may probably be nearly and soon eliminated by the methods that were indicated for that smaller factor, the X-Ray department.

Even in the out-patient work, where no one sees as yet far or clearly, where the swiftly changing conditions in our populations induce constantly readjusting viewpoints—protest and hesitate as we will, a part at least of the solution will come from a fuller recognition of the part-pay patient, and the gradual provision for him under the fullest rights of individual case investigation.

At the New York Post-Graduate, no notable advance has as yet been made in this out-patient field, but work, worthy, perhaps of a moment's attention is being carried on at present with in-patients. About twenty-five per cent of all adult patients (exclusive of private patients) pay from \$5.00 to \$15.00 per week. Such figures may mean little to others because of widely different conditions, but a point of more significance perhaps is that, under an excep-

tionally competent admitting officer, with other factors apparently unchanged, this percentage has been raised about five points in the last two years, years of unusual financial stress.

This proportion of part-pay patients, thought to be rather high considering the applicant class, is believed to be mainly the result of an office policy definitely outlined and persisted in; and it is thought that the effect of this upon the tributary community and on the institution has not been inconsiderable nor invaluable. The pay question is freely discussed irrespective of physician's and patient's first data thereon, and frankest investigation of home and monetary conditions, prospects, friends who may help, etc., is made. If not prejudicial, a day's delay is sometimes advised, that the applicant may consider the obligation and make fairer arrangements. The various investigating agencies are employed, that the hospital may know, not only that the patient can, many times, pay something, but fairly how much. Every effort is made to protect the rights of the family and attending physicians, and their co-operation is being advancingly obtained.

It is noted that patients are coming increasingly prepared for this open dealing interview.

The institution wishes to record (adding to much accumulated testimony) that its probing of supposed cases of abuse reveals ever less than expected, and an especially small amount wherever this open method of dealing may be enforced.

The above are presented as mere illustrative, partial outline sketches of conditions, the slow changing of which is believed to present as a considerable part of future hospital and social progress.

In conclusion: The patient who will pay something has an equal right with the rich and the poor to hospital care, and waits to be better provided for.

The beginnings are well made, but there is demanded more general recognition of his right, with resultant new, franker methods of dealing with the many problems which are found so persistently attaching to this great body of patients.

Communitistic schemes for the satisfaction of this need have notably failed here, and it may be assumed that present organizations and methods will be depended upon, for most part, to do the work.

The work means, in addition to the enlarged receptivity and office burden suggested above, more moderate priced private and semi-private rooms and wards in our extensions and new hospitals, and courage—despite divergent and often selfish interests, to build and feed and nurse and apply dressings with all economy of space, materials and time compatible with good results.

DISCUSSION

DR. GOLDWATER, NEW YORK: A word or two in Dr. Brush's paper requires a little explanation. I understood Dr. Brush to say that in certain instances, patients who applied for admission to ward beds should be given twenty-four hours in which to think over the question whether or not they ought to pay; the supposition being that they had applied originally for free beds, and that in the opinion of the admitting officer they ought to have paid beds. That sounds a good deal like the policy that some hospitals have adopted in times of financial stress: "No money, no beds." I am sure that the American Hospital Association does not want to be understood as supporting such a policy, though they desire correctness in their methods of financial management. In New York City, I think, Mt. Sinai Hospital was one of the first to adopt the system of a financial investigation in regard to the circumstances of every patient admitted as a free case to a ward bed. I believe heartily in that system of investigation, and that is the only possible way to avoid any misunderstanding and to avoid the abuse of the charity of the hospitals, with which we are all so familiar. At the same time, I think it is extremely important that the Auditing Officer should be kept entirely out of this investigation, and that no other question should be considered before the patient is actually placed in bed. If the business of the hospital is properly organized, it will be ample time to bring about a financial investigation of the circumstances within the next twenty-four hours, and then the financial question can be discussed, not with the patient himself, who is supposed to be suffering and is in no condition to discuss such a question, but with his family or friends. I am sure that Dr. Brush will agree with me that he

has no intention of suggesting any adoption of the policy of "No money, no beds." At the same time, his words might very easily have given rise to that supposition, and for that reason I make this point.

DR. BROWN, TORONTO: This paper is full of interest and of points that should take not only a day but a year to think over. It was a most suggestive paper. The thing nearest home is what we can speak best about. In the Toronto General Hospital we have a large number of such cases. I just happened to bring along the census sheet of the day preceding my departure from Toronto. We have for this class in our hospital a capacity of 387 beds; we have for semi-private patients, 40 beds; and for what we call semi-public wards, 34 beds. I think the semi-public ward is a novelty, perhaps, to most of you. In all but our public wards we admit the patients of any physician or surgeon in the city. In our semi-public wards for the semi-public ward patients, we get a dollar a day; for the semi-private wards we get twelve-fifty a week, and for the private wards, from sixteen dollars up to thirty-one dollars a week. We charge a dollar a week extra for surgical ward patients, to cover the cost of dressings. In the semi-public class, the class which is open to the medical profession at large, we have not room enough to accommodate the patients applying for admittance. It is an ever-growing class, and a very popular ward, although I must say, from an administrative standpoint, I do not like it very much. The person of moderate means is a class to which we should give some attention. The Committee on Hospital Training during the year took up that point; I had the pleasure of submitting a paper, which was published in the *National Hospital Record*, on the nursing attention given people of moderate means, outside of hospitals, and to use a slang expression, I do not think they are getting a "fair deal." I think we must do more for them as patients in our hospitals, for many good reasons. It is by this class of patients that our hospitals are really maintained, and we should, I think, endeavor to give value received. My own impression is that all extra charges should be consolidated into one charge. The admitting charge to the patient should cover everything. That is a difficult question, because the surgeon comes in with his fee, the radiographer comes in with his fee and this multiplication of fees injures the hospital. I think if we could get one fee to cover the whole matter it would be a very desirable thing. In order to properly study this question, I think we need more light on the subject. The trustees of our institutions should be made acquainted with the needs of this middle class, and the general public as well. The more we take these people into our confidence, the better, and the more they know about hos-

pital work, the better. I have in mind the way in which Mr. Robertson, of the Sick Children's Hospital of Toronto, has brought the notice of that hospital before the public by judicious publicity, and also by the many pamphlets that he sends out very generously to the public throughout Canada. When the patient comes to the hospital it is only fair that he should understand what fees he will have to pay, and if he is well enough an investigation should be made as to the means he has at hand to meet the expenses. This can be done very judiciously, in most cases, and my experience agrees with that of Dr. Brush in the fact that there is so much less desire to beat the hospital than one generally suspects in these cases. The day after the patient's admittance I go over these cases myself with the admitting officer; although we do not make as close an investigation of these cases as some others. I am firmly of the opinion that we get about all that is coming to us from the patient, as far as his ability to pay. The main difficulty we have is with the farming classes. The farmer comes in who has a hundred acres of land; he sees our rates and wants a bed. He wants to take the lowest rates—\$4.90 or a public ward—and it requires a good deal of persuasion to squeeze him into the \$7 or the \$12.50 ward. We rarely ever get him into those higher rate wards, whether he can pay or not.

MR. BRIGGS, BOSTON: As a new member, who has just joined this Association, I should perhaps assume that I ought to be as timid as the rest of the delegates. On listening to the discussion on publicity, a thought occurred to me, from a business point of view, which I would like to mention. Much discussion has been made of the proper publicity of hospital work and hospital administration in the newspapers. That is something that I think could be done more extensively, and very properly. In addition, a thought has suggested itself to me which can very easily be carried out in the smaller cities and towns, where there are hospitals: the studied effort on the part of the superintendent or manager of a hospital to get the leading and most influential people of every community into the hospital—show them all over the hospital; show them what a hospital means, how it is managed, and how it is conducted. For instance, in every large community there is a Board of Trade or Chamber of Commerce. Get hold of the men who represent that sort of an organization, and plan deliberately sometime to get those men within the hospital, and explain how the hospital is run, what its methods of administration are, and what there is underlying the work. From my observation, the physician is very apt to devote his whole attention to the wards and patients without letting the public know why the hospital is warranted in spending as much money as

its books will show. They do not show them all that underlies the administration of the hospital; they ought to take them to the cellar, to the boiler room, and to the engine room. Take them through the place, pointing out that there is much to be done that costs money; much that is needed to support the primary object of the hospital. Explain the number of people employed in the hospital, the number of nurses, doctors, orderlies, and even those who are employed in the work of cleaning. The expense of keeping clean should be emphasized. All this can be very successfully explained to a business man, and then he will go away with an impression that he has got an idea of the hospital, which appeals to him particularly from the business point of view. This man, returning to his associates in the community, will often tell others of what he has seen, and he says: "Would you care to go to the hospital, and have it shown to you as it was shown to me?" That is building up a public sentiment among the very people who lead in public thought in their community. The best way is to appeal to the intelligence of the individual. They are perfectly aware that there is much work in an institution that is a charitable work, but their own common sense will tell them that there is no need of referring to those things; and in that way you will greatly impress people in a sensible manner. The institution which I represent is a very unique hospital. It is a children's hospital on board a ship, and so unique is it, that people come from everywhere to see it, and it is not very hard to get them on board.

REV. DR. KAVANAGH, BROOKLYN: This paper of Dr. Brush's is a paper that will make our transactions a report of very great value in itself. If Dr. Brush was to study a little further and consider a good many other hospitals in getting his facts and data he might modify one point. I think we are all really doing a very great deal for the middle class. I think that many of our hospitals in New York and throughout the country are beginning to care for them in such a way that a self-respecting person can come to the hospital and pay his way. In the hospital of which I am Superintendent, the price is adjusted according to the circumstances of the patient: anywhere from a dollar up to the ten dollars; perhaps not one-fifth pay the ten-dollar rate in the ward. The Superintendent has it in his power, after careful investigation, to put a patient in a private ward, or even in a private room, under certain circumstances, and allow the patient to be cared for without paying the surgeon's fee, feeling that the surgeon is compensated in part because of his connection with the hospital, a compensation that every surgeon and every physician realizes. Not only are the rich being well cared for, and the very poor well cared for, but we are giving a good deal of

attention. I think, to the great middle class and are not pauperizing them while we are caring for them.

J. B. DRAPER, ANN ARBOR: Turning to Mr. Sutton's paper, I believe that the standard of reporters today has advanced. If you give the reporters honest facts connected with your hospital, nine out of ten will give you a fair report, and give the public something that will not injure the hospital. We find it so. Of course, our hospital is a university hospital, in connection with the University of Michigan, and we do not receive any private patients. All of our patients, as you well know, are in connection with the Medical School, and are for clinical purposes; yet they are well protected. Yet I believe this percentage is very small; and all of you who are connected with universities know that you must have clinical material. Now, the question is, how to get it. We intend to take patients who are not able to pay—patients that are perfectly willing to go before the classes, and we find no difficulty with the hospital of 200 beds. We often have from 30 to 35 patients waiting for admission. That sometimes is a bit embarrassing, for they come there with just about enough money in their hospital rates, and have to stay in the boarding house until we have a vacancy, which is sometimes a hardship. We are now building a new ward of 40 beds, which will help us. The rates charged do not quite meet our expenses, but we hope to be able to bring them to a point where we can. In our case the University has to make up any deficiency where we fall short. Last year we came very near breaking even. I do not know how it compares with other universities. I hope if there are any represented here we may hear from them; and if there are any matters, with reference with our University Hospital that will help any other hospital, we should be very glad to give them to you. If you would like a report of the hospital we would be very glad to send that to you.

DR. ELDER, MACON, GEORGIA: I just want to say a few words in regard to publicity of news from the hospital. In our city, when I took charge of the hospital nine years ago, they were antagonistic about giving out any information to the public or the press, and consequently the reporters handled it as they saw fit. They were always glad to publish deaths, misfortunes, and things of that sort about the hospital, but never said anything about the number of patients that went out well, and cured. I found it beneficial to secure the aid of the press and the public by giving the facts from the hospital. Now one of the local papers has a column devoted to hospital news, and the reporter is practically a question box. If he wishes to know anything about a patient or otherwise, I always give him the news. You can have the co-operation of the press and the

sanction of the public as a whole, in giving out such information, and it meets the general approval of the public and the patient. Of course, operations and things of that kind, that come up are nobody's business, but your doctors, and the officials of the hospital, or the residents therein. As to the fees it is a mighty hard matter to settle. We require two weeks' pay in advance at our hospital. Our rates are \$7.50 a week, and we include everything. We do not have any incidentals at all, only one flat fee with the exception of carriages, wines and things of that kind, which are itemized on the bill. You have just got to do it that way, or else they are going to get ahead of you.

DR. HOWLAND, BOSTON: I cannot quite agree with the gentleman who has just spoken about giving information to the public and the press. It seems to me that if the patient comes into the hospital he is entitled to have his personal ills protected, just as much as he would in a private family. Certainly we should resent a reporter coming to our house and saying, "I understand your wife or some one else is ill. What is the matter with her?" Has not that same patient, when she goes to the hospital, the same right to expect that she will be protected? In case of a great accident or casualty, or when many people are being worried about the condition of their friends, perhaps then it would do some good to give it out to the newspapers and the public, but further than that it seems to me it is not a matter for the press. On the other hand, regarding the things that the hospital is doing in the way of advanced medical science, new treatments, new methods, I think it is important to keep the public interested; also in the matter of new buildings and new construction of any kind. We have in Boston one of the newspapers which publishes a column known as "The Clinic," and I think all the hospitals are glad to give to that paper, information as to things that will interest the public, but that does not include the personal affairs of our patients. A word about the admitting of patients and making of rates. In many hospitals I think the internes admit the patients. It seems to me it is far too important a matter to allow the internes to make the rate when they admit the patients. It is far too important a subject for an interne or inexperienced person to handle. It is a very important matter to do justice to the hospital, and to do justice to the patient. It cannot be settled in a word. It requires a good many questions to find out the truth as to what the patient can pay. If a patient says that his income is \$20 a week, the first thought is that he ought not to stay here if he cannot pay the surgeon or physician anything, and he can afford to go to the private hospital. We must, however, find out how many people are dependent on

this person, and also whether that income is a steady one. Many people are too proud to tell their family affairs. A series of questions will often bring out that they have not been working for a long time, and they are unable to pay at present. Emergency cases should be taken in without question.

MISS EMMA A. ANDERSON, BOSTON: I would not take the time to discuss this paper, except that I want to bring out a new thought, possibly, to most of you. I would like to call attention to a very able article by Dr. F. W. Patch, in a recent number of the Boston Medical and Surgical Journal. He makes the suggestion that possibly hospitals should rightly assume some responsibility for the care of the middle class in their homes, and that that might mean the enlarging of the capacity of the nurses' home. The hospitals, as we all know, are doing splendid work in caring for the middle class, but Dr. Brush brought out the fact that if the large majority of patients and sick folks are in that class, could not we possibly economically use, and rightly use, some of the hospital funds for caring for people in their homes, using our third year nurses for that work and giving them valuable experience. That would be, perhaps, even more beneficial to the family than taking that member away from the home and putting them in the hospital, and less expensive to the hospital.

COST ACCOUNTING IN HOSPITALS.

DR. THOMAS HOWELL,

Superintendent New York Hospital, New York City, N. Y.

Cost accounting may be defined broadly, as an arrangement of accounts, which shows the cost of items of service or production, and also the cost per unit of service or production. In the case of a hospital the item of service is the maintenance of the various wards and departments, the unit of service the patient day.

Cost accounting is not new to manufacturers. Its usefulness in factories is generally conceded.

In times of prosperity the information it supplies renders it of great value to the manufacturer. During periods of depression when competition is keen it is indispensable, and its presence or absence may determine the success or failure of the concern.

The cost system enables the manager of a factory to locate the leaks. It enables him to determine the efficiency of men and methods. Without it, the manager of a so-called trust, would be unable to produce results, he would be practically helpless inasmuch as he would be unable to locate the weak links in his chain of factories.

What interests us as hospital workers is whether cost accounting is practicable in institutions, and, if so, whether it is worth the time, labor, and expense involved.

In answering both of these questions in the affirmative I know that I shall bring down a whole avalanche of criticisms.

One criticism will be that the relations of the various departments of a hospital are too intimate and too involved to lend themselves to accurate cost accounting.

Another will be that such a system is unnecessary, that it accomplishes nothing beneficial to the patients, or to the hospital, that it does not reduce the expenditures, and that it is costly to install and to maintain.

A third will be that hospitals have altogether too much red tape attached to them now, and that just a little more will render them very undesirable places to live in and to work in.

A fourth will be that a cost system will produce only an approximation of the facts.

I know that these objections, and others, will be raised for the reason that when the subject was first presented to me these objections came to my mind, as I was just as antagonistic toward it at that time as some of you are now. But several years experience with a system of this kind has convinced me that I was too hasty in condemning it untried.

I believe that while the cost system is not a panacea for all hospital troubles, it nevertheless has much to commend it.

What it accomplishes is the reduction of all items of expense to comparative costs per capita and per service unit, or in less technical terms, it is a means of finding out what it costs to do certain things. Hospitals are not founded for the purpose of purchasing goods; this is merely incidental. They are founded for the reception and care of sick persons. It seems to me that the patient should be the unit from which to reckon costs, and that emphasis should be placed, not on the total amounts spent for each of the various supplies, but on the cost per day and year of supplying a patient with such items as food, medical supplies and nursing.

There are very few hospitals where any attempt is made to determine costs, with the single exception of the per capita per diem cost, and this is arrived at by a bewildering variety of methods.

Cost accounting can be employed in hospitals in determining various cost facts that are of interest and of practical utility.

Simple cost systems can be employed to great advantage in ascertaining private room costs. Until recently hospitals made little attempt to attract private patients or to furnish them with suitable accommodations. They are now reaching out for this class. Hospital managers think that by so doing they will be enabled to add to their income, and with the increment thus obtained care for more charity patients.

As a matter of fact, very few managers of hospitals which maintain private patient services know whether they are conducting them at a profit, or at a loss, for the reason that they do not insist upon an accurate system of accounting being introduced and maintained.

Hospital officials should have definite, concrete knowledge of the cost of caring for private patients. Having this knowledge they will then be in a position to establish a suitable schedule of rates, and they will no longer be deceived into believing that the private room service is producing a profit, when in reality it is increasing the deficit.

It will be found a simple matter to extend the system to obtain cost facts regarding ward patients, and of accident and out-patient department treatments.

I now wish to call attention, in a very superficial manner, to a system of cost accounting installed in the Worcester City Hospital, in 1905.

Several of the trustees of the hospital own large manufacturing plants. They had found cost accounting systems of great value in their factories, and felt that the hospital might be advantaged by a system of this kind.

*The firm of accountants which was employed to do the work, had not previously installed a cost system of this description in a hospital, but by applying the ordinary principles of accounting to the proposition it devised a system which has worked well in practice and has withstood time and trial tests to the satisfaction of the hospital trustees.

What practical information do the trustees of the hospital obtain through the instrumentality of this system?

From it they learn the per capita per diem cost of caring for medical, for surgical, for maternity and for private room patients, the cost per treatment of accident room patients, the cost per treatment of out-patients, the average daily expenditure for each pupil nurse, the total cost of training a nurse, and the average cost of food for officers, for private patients, for ward patients, for nurses and for domestic help. This information is furnished in comparative form exhibiting the experience of the current year in comparison with previous years.

In addition they are furnished with the per diem cost of each of the following items of expense: food, kitchen expenditure, house officers, nurses, orderlies, other attendants, laundry, medical supplies, surgical supplies, general supplies, dry goods, water, pathological supplies, apothecary department, care of buildings, heating and ventilating, electric light, insurance, repairs, administration and general expense.

DESCRIPTION OF METHODS EMPLOYED.

At the beginning of the year 1905 the company prepared special books designed to record the transactions in such form as would furnish the data necessary to apportion the expenses over the various classes of patients and items of service. The apportionment is made annually from the data furnished by these records, supplemented by additional information furnished by the superintendent, matron and engineer.

The routine work of obtaining and tabulating costs during the year is carried on by the regular clerical staff of the hospital, but at the close of the year the Audit Company furnishes an accounting expert to apportion the costs to the several items of service, and to prepare a statement which is published as a part of the annual report of the trustees.

The cost of house officers, nurses, domestics and other attendants is obtained by charging the salaries, wages, food and other expenses properly chargeable to these accounts, and the costs thus obtained are in turn allocated to the various departments upon the basis of the actual services rendered.

The cost of operating the steam plant is apportioned to heating and ventilating, laundering, refrigerating, lighting, etc., in accordance with data furnished by the engineer. The costs thus obtained are apportioned to the wards and buildings in the ratio of their cubic contents, or the number of lights.

Other supplies are apportioned to the various departments and wards directly, or on the basis of patient days, as the conditions seem to require.

Before reducing the cost of operating the hospital to the items of service the receipts of the institution which are in the nature of reimbursement of expense, are deducted from the original cost of the commodities from which sales are made. For instance, the amount received from the sale of grease and meat refuse, about \$50 a month at the City Hospital, is deducted from the amount paid for meat.

In charging supplies to the Out-Patient Department, private wards, maternity wards, etc., we at first entered the charges as the goods were sent out by requisition each week. We now know about how much these departments use in a year. Accordingly, we have special shelves for each of them, and the supplies are charged in large lots, stored on the shelves, and drawn on when needed, thus reducing clerical labor.

In order that you may obtain a better understanding of the methods employed in determining items of expense properly chargeable to each of the items of expense properly chargeable to each of the items of service I will describe in detail the methods employed in the preparation of Schedule No. 3 which shows the cost of operation of the surgical wards.

Schedule 3.

COST OF OPERATION OF SURGICAL WARDS.

For the Years Ending November 30, 1907 and 1908.

Food	\$ 8,215.82	\$0.232	\$10,091.52	\$0.278
Kitchen expense	2,428.40	.069	2,589.98	.071
House officers	983.15	.028	956.03	.026
Nurses—Sch. 8	11,958.83	.338	10,906.63	.300
Orderlies	2,060.65	.058	2,017.36	.056
Other attendants	732.16	.021	488.04	.015
Laundry	2,320.67	.063	2,266.22	.063
Medical supplies	1,760.03	.050	1,676.39	.046
Surgical supplies	3,275.73	.093	3,863.91	.107
General supplies	1,042.03	.030	1,527.97	.042
Dry goods	1,428.61	.040	1,155.92	.032
Water	162.86	.005	305.50	.008
Pathological department.	806.34	.023	697.10	.019
Apothecary	345.28	.010	308.89	.008
Care of buildings.....	2,966.58	.084	2,582.88	.071
Heating and ventilating.	998.70	.028	1,366.51	.037
Electric light	139.21	.004	174.44	.005
Insurance	335.95	.009	374.54	.010
Repairs	1,906.14	.054	1,854.37	.051
Administration	4,132.59	.114	3,932.21	.108
General expense	860.54	.024	337.14	.009
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	\$48,770.27	\$1.377	\$49,443.55	\$1.362

In 1908.....35,413 patient days—average cost \$1.377 per day

In 1907.....36,301 patient days—average cost 1.362 per day

Increase in average cost.....\$0.015 per day

FOOD.

The per capita cost of food is determined by keeping an accurate record for periods of a week four or five times a year of all uncooked food supplied to officers, nurses, domestics and male help, private patients and ward patients, and at the close of the year striking averages. Not to elucidate the system, but as a matter of interest, I would state in this connection that the average daily cost of food for officers last year was 51 cents, nurses 31 cents, domestics and male help 26 cents, private patients 46 cents and of ward patients 23 cents.

These food costs have been made up about 20 times, and I have been surprised to see how nearly uniform the results

have been, and how well the proportions have been maintained year after year.

KITCHEN EXPENSES.

Includes wages of all persons employed in the kitchen, all kitchen supplies, food for kitchen employes, water, steam used in cooking, power for refrigerating, heating, ventilating, laundering, gas, and dry goods used in the kitchen department.

Distribution—Thirty-five per cent of the cost of the uncooked food supplied the various departments is added to the expenses of these departments, as their share of the kitchen and dining room expenses. In other words, we found the expense of preparing, cooking and serving the food to be 35% of the cost of the raw food.

HOUSE OFFICERS.

Includes food, coats, their share of the kitchen and dining room expense and laundering.

Distribution—Apportioned to those services or departments where they are employed.

NURSES.

Detailed information regarding nurse expense is shown in another schedule.

ORDERLIES.

Includes food, wages, heating, ventilating, lighting and their share of the kitchen, dining room and laundry expenses.

Distribution—According to orderly days in the various departments. The superintendent of nurses keeps a record which shows the number of days of employment of orderlies in the different departments, and her records are used in making the apportionment.

OTHER ATTENDANTS.

Under this heading were included expenses incurred for the seamstresses and the barber, but this division has been done away with.

LAUNDRY.

Includes wages, supplies, food, water, steam, heating of irons, of body ironers, of mangles, etc., heating, lighting, kitchen and dining room expense and general supplies.

The basis of the distribution of laundry costs is determined by making counts for periods of a week, three or four times each year, of the number of pieces laundered for officers, nurses, help, private patients and ward patients. From this test percentages are prepared showing the proportion of laundry expense chargeable to each, and at the close of the year an average proportion is obtained.

Distribution—To the various wards according to the proportion of work done, and also to the following accounts: nurses, orderlies, house officers, other attendants, care of buildings and kitchen and dining room.

MEDICAL SUPPLIES.

Includes drugs, X-Ray expenses and rubber goods.

Distribution—The cost of drugs furnished the out-patient department and special drugs furnished private patients are charged directly to these departments and the balance is distributed to the wards according to patient days.

SURGICAL SUPPLIES.

Includes gauze, absorbent cotton, absorbent waste, adhesive plaster, bandages and bandage materials, rubber goods, etc. (excepting those surgical supplies furnished to the out-patient department, the maternity and private wards, which are charged direct.)

Distribution.—To surgical wards and accident room according to patient days and treatments.

GENERAL SUPPLIES, DRY GOODS AND WATER.

Distribution.—The private patient service, the maternity ward and the out-patient department are charged direct for their share of general supplies, dry goods and water, and the remainder of these items of expense is distributed to the wards according to patient days.

PATHOLOGICAL DEPARTMENT.

Includes salaries and wages, water, heating, ventilating, lighting and its share of the expense of the house officers.

Distribution.—According to patient days.

CARE OF BUILDING AND GROUNDS.

Includes wages of ward maids and porters and their food, kitchen and dining room expense, etc.

Distribution.—According to patient days, excepting in the case of the out-patient department, which is charged separately.

HEATING AND VENTILATING.

Distribution.—According to cubic capacity.

ELECTRIC LIGHT.

Distribution.—According to the number of lamps.

INSURANCE.

Distribution.—According to value of buildings and contents.

REPAIRS.

Includes wages of carpenters, painters, mechanics, and supplies.

Distribution.—According to cubic feet of space.

ADMINISTRATION.

Includes salaries and wages of officers, clerks, door and telephone attendants, stationery, heating, ventilating and lighting of administration building and of apartments of

officers, clerks, etc.; kitchen, dining room and laundry expense incurred for officers, clerks and attendants; insurance and repairs on administration building, and dry goods used for administration purposes.

Distribution.—Over the various departments according to patient days and to the training school according to nurse days.

GENERAL EXPENSE.

Includes conveyance, telephone rentals, sundries, heating, lighting and ventilating of all connecting corridors.

Distribution—Over various departments according to patient days, excepting in the cost of the training school where it is distributed according to nurse days.

Schedule No. 6, showing the cost of operation of the out-patient department, is obtained in a similar manner and need not be gone into in detail.

Schedule 6.

COST OF OPERATION OF OUT-PATIENT DEPARTMENT For the Years Ending November 30, 1907 and 1908.

	1908.	Per Patient	1908.	Per Patient
	Amount.	Day.	Amount.	Day.
House officers	\$277.94	\$0.011	\$272.43	\$0.010
Asst. Supt. and apothecary	894.72	.037	646.68	.024
Nurses—Sch. 8	655.78	.027	677.30	.026
Laundry	112.84	.005	116.82	.004
Medical supplies	393.22	.016	359.70	.013
Surgical supplies	320.55	.013	373.69	.014
General supplies	103.66	.004	85.30	.003
Dry goods	12.32	....	9.48	....
Water	5.20	....	11.26	....
Care of building	712.47	.029	870.20	.033
Heating and ventilating...	774.60	.052	765.95	.029
Electric light	182.20	.008	180.15	.007
Insurance	130.07	.005	145.21	.006
Repairs	730.76	.030	718.98	.027
Administration	666.77	.027	545.35	.021
General expenses	138.70	.006	107.45	.004

	\$6,111.80	\$0.250	\$5,865.95	\$0.221
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In 1908. 24,436 treatments—average cost.....\$0.250 each

In 1907. 26,584 treatments—average cost..... 0.221 each

Increase in average cost.....\$0.029 each

In view of the perennial discussion as to which is the debtor, the hospital or the pupil nurse, it is interesting to observe that the average cost to the hospital for each nurse in the school is about \$1.07 a day. During the first year of her course it would not appear that the nurse reimbursed the hospital for expenses incurred in her behalf, but during her last year she undoubtedly more than does so.

It is evident that the hospital which is hampered by lack of funds should not, for economic reasons, take on too large a number of pupil nurses as each nurse necessitates an annual expenditure on the part of the hospital of nearly \$400.

Other schedules show the cost of operation of medical, maternity and private wards, and of the out-patient, accident and nursing departments. In preparing these schedules, the cost facts are obtained by methods similar to those described in connection with Schedule No. 3.

It should be borne in mind that the system which I have outlined to you may be still further elaborated and refined, by reducing the apportionment to semi-annual, quarterly, or even monthly periods.

This would, however, involve more clerical work, but would produce an added advantage in permitting of comparisons of costs at more frequent intervals, thus enabling the superintendent to take immediate advantage of any leaks or discrepancies exposed.

I do not wish to provide the discussion, but for my own information I submitted the paper I have just read to Mr. A. D. Ludlow, expert accountant at the New York Hospital, who has charge of a similar, but more comprehensive and expensive system, and asked him to discuss it informally, which he did as follows:

"It would be foolish for me to criticise the system of cost accounting devised by recognized accountants, and found by practical trial to work so well in the Worcester City Hospital, but I am certain that no expert accountant can lay out any hard and fast rules that can be applied to institutions in general. There are inside workings and innumerable matters peculiar to each one that only those who are thoroughly conversant with, can accurately adjust

and relegate to their proper places. I do not believe that applying rules for stated periods meets the requirements. To a certain degree this is merely arbitrary, and you are not getting facts. It is better to devise a scheme that shows daily results the year round, and this can be done in a very easy way without any appreciable expense, and not encumbering any particular person with too much detail. For instance, the engineer certainly knows how his men are employed every hour during the day, and the supplies they use. The housekeeper also knows how many she has at her disposal, and their daily distribution. Graduate and pupil nurses have their daily assignments, and so on with each employe—officer or clerk. Time cards giving this information should be deposited daily with some one who would accurately apportion them in their proper places. We have (New York Hospital) a fairly good food distribution, but this can be placed on a fairer basis. There are a number of details connected with it that I could explain and remedy the defects.

"While it is true that hospitals are not founded solely for purchasing goods, it is also true that they are principally concerned in the disbursing of goods, and the mere fact that an institution is richly endowed, has good investments, and a fat bank account, does not make it a success as a hospital, and the only satisfactory method of making the most of what you have at your disposal is by keeping accurate track of how you are disbursing it, and the best and most scientific way is by *cost accounting*, which although it entails a certain amount of departmental detail (and this must be strictly adhered to) it enables one to arrive at and ascertain, both by comparison and facts, where and how to improve, or otherwise increase its efficiency. You are enabled by the information obtained (not alone for economy in cash expenditures) to show us how to get the best treatment, improve methods, increase the service and utilize all resources to the best advantage.

"*Heat, Power, Light.* . Perhaps your idea of cubic area and lamps is all right, but it seems to me you do not get enough information. The New York Hospital has been

doing the same thing in a different way, but it leaves too much to the discretion of the engineer.

"I might add that it is as necessary to be able to get at the cost in a hospital as in any large plant or industry, the only difference being whereas others are seeking to a great extent to increase their receipts, a hospital although more or less interested in that line, is more vitally interested in the disbursing, willing to be prodigal without bordering on the lavish, at the same time economical, but not penurious, and the only way is to have facts to work on, and to get them you must have a system."

DISCUSSION

PRESIDENT: Dr. Howell's paper is open for discussion. Has any other member any such scheme in use in his institution?

MR. ROBERTSON, TORONTO: Do you figure in property depreciation? For instance, if your laundry machinery has to be repaired or you buy a new mangle? Have you been reckoning depreciation for it all the time it has been in use? That is generally done by accountants, and if they did not do it they must have had some good reason.

DR. HOWELL: This paper was written about a year ago. I have not had access to those books for six or eight months. I am no longer connected with the Worcester City Hospital, but, as I remember, they had no system of marking off for depreciation. There may have been such a system.

MR. ROBERTSON: You would have then a completely new outfit of laundry machinery to replace sometime, and the question would come, how would you distribute that in your expenditures? If you had a depreciation account you could take care of it through that account.

DR. HOWELL: I have forgotten just how it was arranged. It was arranged in some way.

MR. ROBERTSON: How do you figure up the expense in connection with the kitchen, and the laundry, and the lighting, and the water? Have you separate meters in the laundry; have you a separate meter in the kitchen, and the pathological room?

DR. HOWELL: Yes, we have a great many meters all over the institution. There are about a dozen of them. We also had at that time a very competent engineer, who is now a consulting en-

gineer. While he could lay out a system that would work all right, I do not believe the average engineer would be competent to determine the distribution of the heat, light, and refrigeration and all that sort of thing.

MR. DRAPER: Every hospital has a repair or building maintenance account where these things are charged during the year. The paper is deserving of a great deal of consideration, more than we will be able to give it now. No doubt it will do us a great deal of good when the report is published and we can look it over. The Boards of Trustees are demanding more and more of the executive officer as to the cost of running the hospital.

DR. BROWN: We have not a system similar to that which they have at the Worcester Hospital, but a system of accounting similar to that which obtains in the hospital over which Dr. Howell now presides, the New York Hospital. Two or three years ago I visited the New York Hospital and was struck with the system of accounting so much that I endeavored at once to have it introduced into our hospital. I found that it cost them \$1,500 to get it introduced. I did not think we could afford so large an expense, so I borrowed Mr. Ludlam's accountant during a portion of his vacation. He came up for a few days and helped us install the system in the Toronto General Hospital. He came up a year afterwards and gave us other valuable advice. Since that time we have been making it go, and are getting more information every day from that system. We have two clerks who look after this work. In the first place before the superintendent approves of a requisition for an article he should know when they received the last one, how much they used it, and whether the requisition represents extravagance or not. Until he knows that he is working in the dark. By this system it is possible to know whether the head nurse, who orders oranges or potatoes, sugar or what not, for her ward, is extravagant. These requisitions come daily to my office, and, I personally, for the last ten months have gone over them. It took us a long time to discover what amount of potatoes, porridge, oranges, lemons, sugar, and other articles to allow each of the eleven departments for each day, for each patient, approximately. After ascertaining the amount we knew whether a nurse was exceeding what was a fair amount per capita, per day. I assure you that the knowledge to a superintendent is a great satisfaction. The result of it has been that we have been able, I think, during the past year to cut down our per capita expense a good deal. The result of having that information daily or monthly, is that you are able to see how one head nurse requisitions as compared with the nurse in another department; and probably more valuable information

even than that is obtained for the reason that you are able to compare her requisitions one month with another; or if a new nurse comes in that department as to whether she is extravagant or not. So far as food articles are concerned, you know each day when the requisition comes before you whether she is exceeding the proper amount or not. For a time we published a schedule showing what was a near amount for each of the eleven head nurses to requisition for her department. Thus letting them know what they were doing and if it was in excess. I took the opportunity of speaking to the nurses on this subject, showing them how much could be saved in an institution where we were feeding 600 patients, if each nurse used one-third ounce per day per patient, of tea instead of one-half ounce, and they were surprised to know what they could save in the institution in one year.

We are this month at the end of our hospital year, and here is a sheet of estimates for the coming year. For instance, in lemons, \$450.00 is our estimate for this year, last year it was \$500.00; our estimate for oranges last year was \$650.00, our estimate for this year is \$610.00; other fruits last year, \$1,450.00, this year \$1,400.00; potatoes estimates for last year \$1,500.00, this year \$1,450.00, a drop of \$50.00. Our entire estimate for last year was \$4,000.00, and we used considerably over \$5,000.00, but we made it up on beef, veal and lamb. For veal we estimated over \$2,000.00, and used \$800.00 worth. In lamb there has been a great saving. We found that we had to economize. Last year we had quite a heavy deficit—nearly \$10,000. This year we hope to have nearly that much on the right side of the ledger. A great deal of this has resulted from our going into this matter of accounting. It is a system which you can develop to the greatest possible efficiency, and something which we could afford to spend four days of a convention in discussing. I am exceedingly interested in the discussion, and am in hopes of having an hour with Dr. Howell before the meeting is over, to find out more about his method.

DR. FREELAND, INDIANAPOLIS: After listening to that mild arraignment by Dr. Bruce Smith, and knowing that he is not very much in sympathy with the Municipal Hospital, I almost fear to undertake to offer any defense whatever. But, if you can conceive of a Republican Mayor and a bi-partisan board, the appointive power really resting in the Republican part of it, and a Democratic superintendent, you might understand that there would be very little politics in that administration. I assure you that if a Municipal Hospital can be shorn of the political part of it, I believe it can be conducted along the same lines as your general hospital. I want to say to you that it depends greatly upon those who

undertaking to help you in the hospital as to how much you will be able to do yourself. I have made a fight for this one thing—that those who are working with me shall be compensated just as much as I possibly can have them compensated, in return for the work which I think they do. In other words, I think good pay brings good employes, as a rule, and unless you have good employes you will be unable to accomplish that which you are aiming at. While we do not carry out just this detailed system of accounting, we have adopted one which we have found very useful. We use a loose sheet system, by which we know every night how much we have bought, and how much we have used throughout the hospital. We not only know how much we have bought and how much we have disbursed, but we know to which department each and every article has gone. I might illustrate that in this way: One of the representatives of a firm came into the hospital one day and wanted to sell us the articles that he was representing; the prices he quoted were in excess of those in which we had been paying, but, looking at his goods, we thought they were better and we purchased of him. Months and months after that he came to sell us again, and to his surprise we were able to turn instantly and find exactly the amount of goods we bought, and the price that we paid for them, and the number we had left on hand. We carry that note from day to day, from month to month and from year to year, and I feel that we have a system that will serve any hospital well. We buy our goods largely after asking for bids, not adhering strictly to the letter of the law, but the spirit. Instead of advertising in newspapers, in getting our monthly supplies, we send a requisition to several of the best firms of the city and ask for their quotations. If we find, for example, that the quotations for drugs for the month, possibly out of four or five good firms, show only 15, 25 or 50 cents difference in all those bids, we consequently know that we are getting drugs at the lowest possible prices. This holds good with our coal and with our ice. We have our milk contracted for, however, by the year. All goods are delivered into the store room, and nothing gets out of the store room without a requisition. That, of course, is the most important thing, not only to see what gets into your store room, but what get out of it. I am almost ashamed to give some of our figures after listening to some hospitals on the hotel plan. Ours is wholly for the poor. We cannot serve patients quite so well, probably, do not give quite such good food, but I do know that we serve good wholesome food, together with fruits, from a clean kitchen, and it only costs us eight cents a meal to do it. I want to say to

you that I partake of the same kind of food, and I have gained twenty-five pounds since going to the hospital.

DR. HOWARD, BOSTON: I would like to say a word about the terraced pavilion hospital. When the title of that paper came to me in the announcement of this association, I was probably as surprised at it, as one explorer was to know that some one else had been to the North Pole, for this reason: In working over the plans for the Peter Bent Brigham Hospital, when we begun to study the shadows that surrounding buildings threw upon the land, we begun letting back the second story from the first, and when we began studying the shadows that each hospital building cast upon the others in the months, especially of November, December and January, we began setting back the second story from the first on the sides, so that today the plan which we have prepared, or rather the architect has prepared, but which has not been accepted, and may never be built, was fairly designated by the title of that paper, *The Terraced Pavilion Hospital*. We have not worked all the details into it as yet, but it is the most probable plan. It meets with more approval among our board than any plan yet produced, and seems to meet with more approval among superintendents that I have shown our various plans to, than any plan we have produced. I do not know what is in that paper, and I cannot discuss it intelligently, but what I wished to say was that we have been working on the same lines. We have got an infant plan, at least, and it seems to be designated by the same name. Whether we allow it to grow up to manhood is a thing that I cannot promise.

The other paper, in regard to public assistance of private institutions, I would like to say just a word about. I think it may be a good thing, in a sparsely settled community, where no hospital exists—that is, it may be a necessary evil to start a hospital, that is called a private hospital, by giving them public funds, to help along, but in a thickly settled community I do not believe that there is any argument that would hold good. To allow these private charities to draw on public moneys to help along I do not believe is for their own good; it saps their energies. I know of an institution that has always had state aid, and I feel sure that I know of several instances where they have been left out of the will of rich people dying in that community, simply because of this little paltry \$15,000.00 or \$20,000.00 taken from the state each year. They have got money enough to run without it, if they only knew it. It is like the child that is always leaning, after it becomes a man, upon his parents, for a little more aid, rather than trying to stand alone and walk alone, and attend to his own affairs. This state aid of private charities, it seems to

me, is somewhat similar to our national tariff—a good thing to help infant industries; but you know well from the discussion of the tariff the past ten or fifteen years, how hard it is when they cease to be infant industries, to get them to give up tariff. They have had this aid all this time, and they cannot stand alone; they want that aid still, and it is so with these private charities, that they have always had a little aid that they could surely count upon from the public. But the serious part of it, is that it saps their own energy to produce funds; and it spreads abroad the reputation of receiving state aid, and keeps many charitable people from remembering these institutions in their wills.

PRESIDENT: We will be glad to hear from any other member.

MR. BAILEY B. BURRITT, NEW YORK: I do not know whether visitors are welcome to make remarks. I was very much interested in the whole trend of Dr. Goldwater's paper, because I did feel that the question of the separate functions of the municipal hospitals and of the private hospitals are important. In looking over a question of this kind, we make a mistake in simply looking at a cross-section of it. The development of the poor laws in England is interesting in this connection. In the first place, charity was then altogether a function of the church. It took years and years to establish the principle that it was better to do some of the charitable work through the state; in other words, to establish the principle of drawing upon the public for charity. It took years for that principle to get started at all, and when it did start it started in the way of helping those charitable organizations which had previously carried on that charitable work, but were handicapped because of the lack of funds. They have gradually developed that principle. The most important field is the field of education, and that, by the way, is analagous to the hospital situation. There is friction still between the private school and the public school, but that friction is much less than it was formerly. It seems to me that the principle that has preceded the development in the educational field is illustrated in the hospital field. We started out with private schools, doing all the work practically in this country. Then we begun gradually with the development of the public schools, and the recognition of the right of a person to an education. We recognized the fact that if he were educated in an institution supported entirely by public taxation, the education was not looked upon as a charity, and it was not pauperizing. It is quite as essential for the state to have able bodied citizens as it is to have well educated citizens. It seems to me it is quite as much a function of the state to give the necessary hospital support to those persons who are not able to provide it for themselves, and perhaps, in some measure to those who may only

by crippling themselves in other ways be able to support themselves in a hospital. If, instead of taking a cross-section view of the hospital situation at the present time, in comparing those hospitals which are municipal hospitals, supported by public taxation entirely, and those hospitals which receive subsidies from the state, if we look at it from the point of view of the development of municipal hospitals, I think we will get a new and important point of view. In the early history of the country, if I am correctly informed, almost all, if not all, of our hospital work was done entirely by the private institutions. Gradually, the principle having been applied in other fields that it was the function of the state to care for the poor just the same as the state cares for the blind, the idiotic, etc., in state institutions, so it came to be seen, more or less, that where the state had to provide funds for the poor that happened to be sick, it could be done in many cases more advantageously in the institutions carried on entirely by the municipality or by the state, and supported by public taxation. We are in the beginning of the development of the municipal hospital. In New York we are witnessing a very great development of the municipal hospital at this time, and we are encouraged to think that it is a fortunate development. I am perfectly aware that there has been considerable politics in connection with municipal and state hospitals, but there is no more reason why there should be politics connected with public hospitals, than there is why there should be politics connected with public education. It seems to me it is just as possible to develop a system in which politics will be just as free from it, as it will from our system of public education. That is a somewhat new point of view from that presented by Dr. Goldwater. Many of you will not sympathize with that point of view. If I were a superintendent of a private hospital I should probably be more or less opposed to it. If I was a superintendent of a municipal hospital I should feel a little bit one-sided there; but, by being connected with neither kind of an institution, and looking at it from that position, it seems to me that there is a distinct function for the private hospital. It is evident that, where the cities are large enough for the municipality to establish hospitals for its own sick poor, it probably can be done more advantageously by having institutions of its own, supported by public taxation, rather than by subsidizing private hospitals to do it.

DR. BRUCE SMITH: In answer to the statement of the last speaker, I may say that I stamp with disapproval all municipal hospitals. I have never yet seen a municipal hospital that can exist for any length of time, and commend itself to the support of those who know how a hospital should be conducted. I am glad to

know from the paper that we have heard, that the idea of municipal hospitals, instead of growing in favor in the city of New York is growing in disfavor as well as in nearly every state in the union. We want no municipal hospitals if we can possibly avoid it. Municipal management is well enough for public works, for street railways, for electric light, and other similar franchises, but keep them away from the farming out of the care of the sick. We have three municipal hospitals in Canada, but in those centers there is so little local philanthropy, that the benevolent people of those cities would just as soon think of giving a contribution to the street railway, as they would do their municipal hospital; that sentiment is found everywhere. Probably Dr. Goldwater does not know what an important duty he has performed in presenting that paper here today. I think that he has enriched hospital literature in a manner that we will fully and better appreciate when the report of this association is published.

DR. E. P. MAGRUDER, WASHINGTON: I have been connected with the Charities Department of the District of Columbia for nearly ten years, and having been an institution superintendent for over thirty years, perhaps I might be able to enlighten you a little on the way the hospitals are conducted in the District. I am very glad to have heard Dr. Goldwater's paper. I quite agree with the gentleman who first opened the discussion. I certainly cannot agree with Dr. Smith who has just spoken in the matter of municipal hospitals. The history of the District of Columbia has shown that hospitals have sprung up here like mushrooms, and the first thing they would do would be to try to get an appropriation for their maintenance. When they succeeded in getting an appropriation, the next year they were back for another, and the next year for another, or an increase, and so on, until finally it reached a point where nearly all the hospitals were receiving public subsidies or were supported entirely by public subsidy. Some of them, in fact, made no attempt to raise money from private sources. That condition went on. I have in mind an institution where one of our most philanthropic citizens was on its board of directors. He gave to that institution a thousand dollars a year—that was his contribution. He was also on the board of directors of another institution, which received a subsidy of some twenty thousand dollars a year. His contribution to that institution was nothing. The philanthropic people would then think, "Well, that institution is supported by the government, and it is not necessary to give to it." The District of Columbia has commenced to lay plans for a municipal hospital. These private institutions were too selective in their cases. They would take no patients at all except the acute, leaving

the chronics to be looked after in the best way they could. For a number of years, it was no unheard-of thing for an individual to die in an ambulance, while being carted around from one private hospital to another, with the District knocking on the door asking admission for that patient. At the same time those institutions were receiving appropriations for charity work, so specified, of from \$5,000 to \$25,000 a year. It was for this reason that the District has started a large municipal hospital. The Tuberculosis Hospital of the District, of which I am superintendent, will be the first section of the municipal hospital. Additions to the Tuberculosis Hospital will be made from time to time for the care of such chronic patients as the private institutions refuse to accept; and it is hoped that within a short time, a large municipal hospital will be developed. I think it is the policy, and duty, of the state to take care of all its dependents at its own expense, no matter what the class may be. Whether it is dependent children, or defectives, it is the province of the state to take care of them. If a man is sick and is poor it is no disgrace.

T. S. PENDERGRASS, SALT LAKE CITY: In one of the papers this morning the statement was made that each person is an integral part of the American Commonwealth, and as such he should bear a part of the burden. It is only just that the American commonwealth, as a commonwealth, should take care of the indigent poor and that the function of the private hospital is not to take care of the poor at all, but is to provide a place where that middle class—that great majority of the American public—can be taken care of and not be pauperized, as they many times are being pauperized by being forced into our charitable institutions and branded as a charity patient. When once you kill a man's pride by making a pauper of him, you immediately make him a beggar for the rest of his life, unless some financial turn in his condition is brought about that will place him in a different class altogether. In other words, if once you make a man come to you as a beggar, he will be perfectly willing to join the great class of beggars, and be a beggar for the rest of his life. It seems to me that a plan that we have away out in the western part of the country, in the mountains, whereby the middle class is taken care of, might be interesting to you for just a moment. The miners and mechanics pay so much per month into a fund, and in case any one is sick or injured, their expenses are paid for at the hospital out of that fund. In this way the middle class can be taken care of, and they are taking care of themselves, and you are not pauperizing them in any way. That is done throughout the mining camps. Thousands of people who are on our lists today are paying into the hospital one dollar

a month, and that dollar a month takes care of any man or any member of his family that may be taken sick under any conditions. The private hospitals should avoid receiving municipal aid in every way they can. I do not believe that any hospital has a right to expect municipal aid or state aid in any way, shape, or form. If we do that we immediately give the state just exactly what Dr. Goldwater stated, the right to come in and dictate to us how we should run the private institution. If the state is to educate the people—the children of the state—I do not see why they should not take care of the indigent sick.

A MEMBER: There can hardly be any doubt that the city or the state are compelled to take care of their poor sick, just as well as they are compelled to keep law and order. In places where there are no municipal hospitals they have got to appeal to the private hospitals, just the same as to the telephone company or the gas company to supply them with gas or telephone service. Dr. Goldwater did not intend to appeal to the city or state for aid. He would rather consider that he wanted to be reimbursed for services rendered to the city or the state. I think that is the correct standpoint, with certain restrictions. Before I came to this country I was in Berlin, Germany, in charge of an accident station, and very often we had to render first aid to people who were dependant on the city. In such cases we would receive a compensation from the city, provided we could prove that there was an absolute necessity for rendering such service. The private hospitals in New York city and in all larger places were founded individually with a certain object in view. There were different nationalities who founded hospitals—German hospitals, French hospitals, Swedish hospitals, and so on; and then different religious denominations founded hospitals—Catholic, Jewish and others. These hospitals were founded for the benefit of people who preferred to be treated by physicians and attended by nurses of their own faith, creed, nor nationality. The city cannot be expected to cater to such special likes or dislikes. All we can expect of the city or of the state is to give the poor sick medical or surgical aid. They are expected to do it, as well as they can, at the lowest possible expense. When any of New York city's poor sick people go to the hospitals, other than public hospitals, the city should only be expected to pay for their care and treatment if it can be proved that there was no other alternative. For instance, in accident cases, the nearest hospital should be used; and the city should pay for their care. In cases of acute illness, or in emergency cases, the city should be expected to pay for their care, unless a city hospital was near enough to take the patient there without endangering

his life by the prolonged transportation. If the private hospitals on one hand and authorities on the other hand, would adopt such a plan that the compensation should depend not only on the proof of the poverty of the patient, but also on the necessity of taking the patient to that hospital, I think no objection could be raised.

PRESIDENT: I am sure we all want to hear Dr. Goldwater in closing the discussion of his paper. There have been different views expressed here, and we would be glad if Dr. Goldwater would reply.

DR. GOLDWATER: My main purpose in preparing the paper which will be printed in the report was not in approval of what you call state aid, but what really ought to be called aid of the state. I gathered together for convenient reference, certain facts in regard to public appropriation for the partial support of patients in private hospitals in the United States and Canada. Those facts have nowhere been collected before, and today they are not, so far as I know, available in medical literature. Dr. Howard has instanced a case where a hospital had been cut out of the will of wealthy people because of its co-operative relations with the state. That might have happened. If so, it was due primarily to one of two things: either the system of co-operation was a system of state aid, or else it was due entirely to a misapprehension on the part of the person who was making the will as to the work the hospital was doing. In New York the system of co-operation between the city and the private hospitals has existed for a great many years. Three or four conspicuous hospitals have refrained from accepting state aid for two reasons. Some of them had stated frankly that they wanted no assistance and no state interference, that state interference is a danger and that some of their affairs are private, in which they do not want the state a participant; although the hospitals receiving aid in New York city have asserted and do assert today, that such state interference as is practiced does not in any way affect the value of their work to the community. State interference in the form in which it is generally spoken of does not exist and cannot exist. I have one province in mind where the powers of the state inspector are extreme. In that province he has the authority to direct the medical work, to fix the religious services, and do a thousand and one objectionable things. None of those things are done, as a matter of fact he confines his inspections, reports and suggestions entirely to such matters as are of common interest to the state, to the hospital, and to the patient in the hospital. The private hospital should not go to the public treasury to be fed. Private hospitals are in a position to do work which the community has accepted as the responsibility of its own, and

the private hospital is able to do that work more efficiently and economically than the community can do the work itself. I know of one institution, a private hospital, where six-sevenths of the cost of the maintenance is furnished by private parties, and only one-seventh is furnished by the community. It is carrying along every phase of its work satisfactorily to the community. It receives their donations and bequests and is growing at a rate which compares more than favorably with the growth of those hospitals which abstain from donations from the state. Apparently, no hospital in New York city has suffered in the manner Dr. Howard has suggested. The state, in the first place, must put up an enormous plant and maintain it. It was recently shown that a city hospital in New York city had a maintenance rate rather favorable as compared with the maintenance rate of private hospitals, but on analysis that hospital was found to be practically a hospital for chronics, not a hospital having different classes of patients, and therefore on an entirely different basis. Where you find in the community public hospitals and private hospitals side by side, you almost invariably find the same service to cost more in the municipal hospital than in the private. It has happened in this country that municipal hospitals have been recently erected. It is happening today that municipal hospitals are coming into popularity in a great many places. Nevertheless, if we want to look at the historical phase, we must admit that where one municipal hospital is started today ten, fifteen, or twenty private hospitals are being erected. The community is not strong in favoring municipal hospitals as against private hospitals. It is true we can see that the system of co-operation with the state has been abused here in the District of Columbia, and that the private hospitals of the District of Columbia are obtaining more than a healthful part of their support from the public treasury. As a matter of fact, there is no such thing as equality in appropriations here, or control of such appropriations. While the District of Columbia organized a per capita, per diem system, which apparently means equality, responsibility and accounting for every dollar expended, as a matter of fact the hospitals here have a habit of going to the House of Representatives and obtaining appropriations for special purposes which actually defeat the purpose of equal appropriations, and is entirely contrary to the principles of per capita appropriation. State aid is a decidedly misleading term. As a matter of fact, the hospital co-operating with the state is not being aided by the state but is aiding the state, and in every instance furnishing the plant which the state requires for the care of public dependents. Where the system of co-operation exists it has been found on striking an average that the proportion of the maintenance cost of the patient paid by the state does not average over thirty-five per cent.

THE TERRACED PAVILION.

BY DR. D. SARASON,

Berlin.

A prize contest, inaugurated by the King of England seven years ago, for an improved plan for an institution for the cure of tuberculosis, has led me to reflect whether the prevailing principles employed in the building of hospitals are sufficient to ensure a construction perfect in every detail, or whether there still remains the necessity of improvements and reforms. If the latter were not the case, the merits of any new plan could only consist in the exploitation of the given local and financial conditions, in the skillful combination of the necessary rooms in accordance with the prevailing principles, in the grouping and spacing of rooms for the purpose of the most rational administration in housekeeping, feeding, nursing, medical attendance, and research; in the exploitation of all known technical methods used in cases of emergency to create advantages of various kinds, and in the thoughtful consideration of aesthetic demands.

An unprejudiced examination gave the following results: Any hygienic demands which reasonably may be made in planning an abode for the sick—ample air, an ample supply of light, sufficient room, provision for the greatest possible cleanliness—are universally given prominent consideration in the modern hospital. Other demands are more or less perfectly fulfilled, as far as this is possible, with the existing excessive decentralization of large hospitals made up of two-story pavilions.

In contrast with this, however, a decided therapeutic want has long been felt. It is one which seems destined

to occupy a more and more prominent place in the entire treatment, especially when a better opportunity is offered to do justice to its far-reaching importance. I refer to the *open air cure*. In trying to meet this need in the construction of buildings of recent date, hygienic sacrifices have been made without really accomplishing the desired object. In this direction reform is needed. I therefore submit ways and means to accomplish this, being convinced that the utility of hospitals may be increased in an unusual degree, not only by making the inside rooms absolutely unobjectionable according to the rules of hygiene, but also by adding outside spaces uniformly to all the stories, in order to offer perfect open-air cures in immediate conjunction with the living rooms.

Before discussing the vital point of the matter, it seems proper to mention the limits put upon the perfection of hospitals, which, as indicated before, are the result of the increasing decentralization of large institutions.

In the first place, the conspicuous fact presents itself that we have lost sight of the consideration of the hospital from an economic point of view; the hospital has been regarded wholly as a charity. We content ourselves with making our decisions entirely in accordance with the greater or lesser principles which are considered essential in ministering to the needs of the sick; we do not consider that the space necessary for the application of these principles, especially in conjunction with the increased technical and general demands of our time, results in an enormous per bed and per capita cost, so that, with the constant increase of other social problems, and with the disproportionate means available at present for carrying out all that seems desirable, it has become impossible to keep step with the growing demands in the care of the sick. For I am of the opinion that the number of five per 1,000 of the population, at present recognized as the minimum number of beds to be maintained by a community, might be materially increased as soon as the prompt accommodation of the indigent sick for a proper length of time is recognized as an important part of social economy.

Only in this age, which is so little given to profound thought, in which judgments of mood instead of judgments of value predominate, could one accept as the height of perfection, as well as a wonderful monument of social provision, a Berlin hospital which has built 2,000 beds for about nineteen and one-half million marks, and which had to register 6.38 marks per day as the cost of food for each patient, as its expenditure, of which 5.05 marks had to be borne by the city.

This point of view is in direct contrast to the aim of social economy, whose duty it is to judge each and every charitable institution as an arithmetical problem, according to the embodiment of individual factors, whose value is to be judged purely objectively. The perfection of a hospital must therefore never be judged by its absolute size, nor by the quality of its construction, but solely by the number of hospital days attained as a result of the sum expended, thus making the standard of value for the economic achievement of a hospital as follows: The *cheapest hospital bed*, the *cheapest hospital day*, maintaining at the same time the *best conditions* for *therapeutical success*, so that a larger number of patients may be cared for (at the same expense) than has been possible heretofore. To continue: The highest aim of every hospital is naturally to provide the best conditions for therapeutical*success. But how does this hold good in institutions having such enormous expenses, or even those having nearly as great an expenditure, as the one mentioned above? It might be that this money would furnish therapeutical values of such great superiority that the larger productivity of human labor, which would result, with all the consequences that would ensue, should outweigh the enormous sacrifice made, and thus prove the investment a rational one after all.

Unfortunately, the answer to this inquiry is entirely unsatisfactory. These "cities of the sick," as these modern gigantic institutions are proudly but unjustly termed, not only do not furnish better conditions for recovery, but, on the contrary, in certain directions their results are inferior, and the very factor which causes the surplus of buildings and running expenses, their exaggerated decentralization, is at the same time the cause of their inferiority.

The latter is owing to two causes, the first of which is the *complication and difficulty* of *medical supervision* and of *administration*, which are not unimportant to the interest of the patients. The second reason, however, is of still greater importance and bears positively and directly upon the question. It has reference to the *disadvantages of maintenance in cases of great decentralization*. It is Dr. Wilhelm Steinberg's merit to have convincingly shown, in a lecture delivered before the International Congress for Hygiene, at Berlin, how unfavorable an influence it must certainly have on the patients to receive their food in a stale condition, owing to the great distance of the wards from the main kitchen.

In view of this, which causes the enormous and disproportionate expenses of the modern large hospitals to appear still more irrational than they are in reality, the question presents itself more urgently and more unavoidably: *Is it not possible to compromise between the barrack-like arrangement of old-fashioned corridor buildings and the oppressiveness of exaggerated decentralization employed at present?*

The answer must naturally be: By doing away with the two-story pavilion type, putting larger hospital communities into higher buildings. Nolens volens, we have already resorted to three-story pavilions in latter-day buildings. But I believe that four-story buildings will soon be adopted in response to economic needs, i. e., to give as many needy patients as possible the benefit of hospital treatment. In America, the original home of the cottage hospital, in places where not too great a number of patients have to be considered, and the demand for technical perfection is not so great, it is considered imperative in large cities to erect five and seven-story hospital buildings, without seeing, thanks to the high measure of technical perfection possible today, any retrogression in therapeutic conditions by reason of the larger powers of accommodation. Thus, for instance, the luxurious Mt. Sinai Hospital, in New York City, consists of five-story buildings, while the new buildings of Bellevue Hospital consist of seven-story pavilions, as I had occasion personally to observe.

I do not desire to endorse this method unconditionally, but rather to point out in what ways our views are at variance with it. It is claimed that the pavilion principle, which allows the erection of buildings of three and more stories, necessitates a reduction of the free supply of fresh air which it is desired to give the patient, as in the cottage plan. The disadvantages of the above mentioned principle do not consist merely in the fact that a larger hospital community must necessarily vitiate the air of the interior by communication of the many doors, floors, ceilings, and stair cases, but these disadvantages are augmented by the unfavorable exchange of the inside and the outside air. The more points of access a building offers to the outside air, the quicker and more complete will be its ventilation. Now, as the size of the contact surface is in reverse proportion to the size of the cubic space, a two-story building with a smaller cubic space, must possess more surface in proportion to the space than a three-story building, and therefore the exchange of air in the former must be more favorable than in the latter.

Granted that the demands based on this ideal of the low pavilion, having a maximum number of eighty beds for a hospital, as stipulated by Prof. Lebenhartz, be fulfilled in spite of the ever increasing difficulties of present conditions (economic as well as industrial) the question would still present itself: is there no technical possibility of doing away with or minimizing the premises of this severe postulatium, so that even the most insistent hygienist would agree to the rational centralization of hospital equipment? This possibility is what I believe to have attained, conjointly with the success of my attempts for the improvement and wider distribution of open air cures. And thus I have returned to my starting point. By reason of wide experience and numerous careful experiments, it has become a matter of positive knowledge that open air cures, *i. e.*, the method of placing the patient where he may obtain the benefit accruing to him from constant contact with the air, may bring about a decided complex of subjective and objective co-relative processes in the body, invaluable in curative properties.

Following independently some individual pioneers of earlier times, Brehmer has laid the real foundation for this in his rest cures planned especially for tuberculosis of the lungs, which he has carried out with great energy and systematic thoroughness. The reclining halls, which he has erected for this purpose in the open air, are, however, inadequate. The separation of these halls from the ward requires paths leading to them; now, as the will-power of a patient is weaker than that of a person in good health, in regard to exercise, this separation detracts from their accessibility, particularly in the case of bed-ridden patients, making them more dependent than ever on the assistance of the already overtaxed help; but, above all, these halls do not permit of a veritable open-air cure in the full sense of the word, because of the necessity of their being covered, to guard against exposure in sudden changes of the weather, and because of the impossibility (resulting from the distance at which the reclining halls are placed) of an immediate retreat to the ward. Therefore, when a number of patients are assembled, the air is apt to become foul; and even when certain parts of the roof may be opened like windows, or the whole is so constructed as to be lifted up entirely, this does not furnish an equivalent for a stay in a garden. The latter offers the possibility of remaining out doors under all circumstances, permitting the body to be bathed by the *constantly circulating* air and flooded by sunlight, either in its undiminished power, or by occasional evaporation, by the use of awnings or similar contrivances. In case of great wind, movable walls are advisable. Awnings may also give protection against rain, unless sheltering baskets placed over the head of the bed are preferred, with waterproof covers over the rest of the body. Besides this, the patients may be placed close to the glass doors, separated from one another by narrow posts, in rainy weather, so that the balconies projecting one meter (a little more than a yard) would give additional shelter, leaving the ward to be used as an open, heatable, reclining-hall.

In the first place, that which gives to a stay in the open its superiority to a sojourn under a roof, is, in addition to the unobstructed influence of the light in the open, the unimpaired circulation of the air, with its natural wind

currents. This it is that refreshes and revives the organs and helps them to resist disease better. This fact, easily perceptible by the senses, has received an exact scientific basis within the last ten years, by the words of Krieger, 1899 (*The Value of Ventilation*), W. Mehl, 1903 (*Standard Measure of Carbonic Acid, Poisonous Breathing, Standard Deprivation of Warmth*), and particularly by studies of Feugge and his pupils (*Magazines for Hygiene*, 1905).

Let me here mention briefly that the newer tendency in hygienics, based on these studies, in contrast to the belief still largely in vogue, that the value of fresh air is measured by its chemical purity and its amount of oxygen, does not recognize in these factors the reason for our good condition in the open air, but only in the fact that the body is deprived of warmth, which frees it from an oppressive stagnation of temperature (of which we are often unconscious), by reason merely of the mobility of the outside air, which often works in this manner in contrast to the inside air, barring even any difference of temperature—as well as by reason of the stimulus to the skin, caused by the action of the air, which likewise contributes to the activity of all cellular processes. Entirely harmonious with this is a fact for the knowledge of which I am indebted to a conversation with Dr. Lawrence F. Flick, of Philadelphia. Dr. Flick, who is one of the noted phthisistherapeutists of America and who was the president of the International Congress of Tuberculosis at Washinton, stated with particular emphasis that according to his long experience as the director of the Henry Phipps Institute, the character of the air in its chemical relation, plays an essentially minor part, as compared with the fact of the body's being exposed to the freely circulating air.

Whenever the latter is made available for the patients in the most approved manner possible, the best results are obtained, while the purest air in the most favored climate produces comparatively no effects where this is neglected. Although Dr. Flick's Sanatorium is situated in the center of a large city like Philadelphia, and accepts only the worst cases and moribunds, he shows a mortality of only twenty-five per cent. He attributes this principally to his efforts

to give a "real open air treatment," *i. e.*, a treatment under the open sky, and considers the psychological influences employed by him, such as conditions inducing a cheerful mood, as much a factor in producing good results as (what is taken for granted) good nourishment.

In order that large institutions may profit by this method with ease, at all times, he has evolved the same idea as I myself did, although he has done so independently of me, and several years later.

He embodied this in a model exhibit by him at the Tuberculosis Congress at Washington. Dr. Flick's experience in combating tuberculosis also seems of great importance in a social-economic sense, for if it be true that equally good provisions for the successful treatment of consumptives may be made in the air of a large city, as in more favored climates, it implies a greater possibility of cure for the great majority of tuberculosis patients.

We see, therefore, that it is an absolute necessity *to utilize the natural mobility of the air for open air treatment and in as unlimited a manner as possible, which, however, is only possible under the open sky.*

For in the case of wards (like our present reclining halls), which are closely covered on top, and open on only one side, because an opening on both sides would cause a draught, the velocity of the original aerial movement is so greatly diminished that a much slower circulation of the air results than is generally supposed, and where the covered space is very deep and the difference between the inside and outside temperature only a slight one, a stagnation of the air may set in altogether.

The difference between the movements of the air, in a covered space and under the open sky, may be plainly noted by the immediate increase of one's feeling of refreshment when stepping out on a quiet day, from under a loggia, which happens to have an uncovered balcony extension to the front part of the balcony.

Only in one case can covered spaces facilitate a sufficient circulation of the air, namely, when they are in rapid motion, such as covered wagons and especially the promen-

ade decks of moving vessels. Even here one has to renounce the important factors of complete light and an unlimited view, which a stay under the open sky affords.

This deprivation is certainly a disadvantage in the treatment of the sick, for Prof. Rubner very justly says in his dissertation, entitled "Guiding Principles for the Building of Hospitals," after having first spoken of the great importance of fresh air and having emphasized the fact that there is foul and stagnant air even in the best ventilated rooms: "A second cardinal condition of health is light. It bears the closest relation to our health and exercises the most powerful influence on the nervous system. One's mood in health, and still more in illness, is dependent on sunshine. Altogether, the value of moods has not yet been sufficiently recognized as a factor in the treatment of disease, and yet the state of mind of a patient is often of enormous and decisive influence in his improvement and cure. In a greater or lesser degree this is the case without exception, as the psychological condition of a patient is hardly ever unimportant. Either it smoothes the progress to health or it blocks the same. For this reason, too, a sojourn in the open air is valuable, in order to influence the mind by as unlimited and friendly an outlook as possible.

Reclining rest cures in covered halls may therefore, as it will now be granted, be considered only an inadequate substitute for a complete open air treatment. This is still the case when the halls are planned to adjoin the wards on all floors, as has therefore been universally done and this is the hygienic retrogression to which I referred at the beginning of my lecture. It is true that two great disadvantages hitherto embodied in the reclining halls are hereby avoided, first, the transportation of the patients to the open air treatment, and secondly, overcrowding, because each hall is intended only for the accommodation of one ward; and yet the patients lying in the halls may be scattered over the whole house without satisfying the demand for open air cures under the sky, except on the top floor, since the upper veranda must naturally cover the lower one.

Furthermore, in cutting off the sunlight and limiting the circulation of air, as must inevitably be the case, even in high wards, where verandas three meters deep are built

against the wall, we are violating a rule that has always been regarded as fundamental, namely that wards be lighted from two opposite sides.

In his dissertation quoted above, Prof. Rubner says: "In a ward the light must be allowed to penetrate the farthest corner. Light ensures cleanliness, and cleanliness insures health." If, in spite of this, we have not hesitated recently to adopt such a decided and obvious retrogression in hospital hygiene, it only goes to show the *exceptional urgency and overwhelming importance of an immediate connection between the sick room and the open.*

Exposed balconies, also, at the ends of the pavilions, or connecting buildings, have, apart from the inadequacy of the corridor-like character of the lower story (which of course remains), the same faults as distant resting halls.

In the face of this situation, it became quite clear that a reform could be accomplished only on an entirely new basis of construction. I therefore made the following demands, which it had hitherto been impossible to satisfy:

1. To provide direct balconies, level with the windows of all the front rooms of every two-story or higher house, two to three meters deep, such as are necessary for open air cures.

2. To extend the balconies into the open air in each story.

3. Not to interfere with the access of the light and the circulation of the air in the living rooms, by fulfilling these demands, as would be done very materially by erecting ordinary balconies of similar depth.

By this method it would become possible for all the inmates of a house, the sick and the well, those able to walk as well as those confined to their beds, even fever patients and post-operatives in their beds, to be removed without any trouble, right out of the window, at the same time, on every floor, out under the open sky into a space sufficiently large for the purposes of open air treatment, and to be taken back again just as easily.

The solution of this decidedly far-reaching problem has become possible only through this one idea, the supervising simplicity of which reminds one of the egg of the Columbus story and the cutting of the Gordian Knot. The peculiarity

of such ideas (which are of course so simple that any one might conceive them) is that they originate only when one has a clear comprehension of the alternative: one must either adhere strictly to the given conditions, and give up the attempt to conquer the problem, as is generally done, or by relinquishing certain conditions, heretofore considered indispensable, arbitrarily create new conditions, which make a solution easily possible. Naturally a sufficiently critical conception of the full value of the desired aim, as compared with the unavoidable sacrifices which have to be made for its realization, is necessary in order to make this change a profitable one. Under ordinary circumstances, however, we are prevented from reaching this conception, which the general public attains sooner or later (*after* the problem has been solved), by the natural lethargy of our minds. Only an unusually strong will power can enable the mind to step out of the ordinary beaten track to break through the isolating resistance of traditional ideas and find new associations. Feats of the Columbus egg order are therefore more a product of strong will-power than of laborious thought. As the former, however, is much more rarely found than the latter, it is our fate to recognize the simple and obvious solutions of important problems with great difficulty and generally only after roundabout methods of doing the work have long been in use.

In the present case the idea which easily led to the fulfillment of the above named three conditions, consists in setting back the front wall of each upper story against the lower one, thus forming terraces before the windows of each floor.

This new and original architectural conception, which will naturally be called the terrace system, could, however, be realized with great difficulty, because a decrease of two and one-half to three meters from the whole width of each floor not only necessitates too great an economic burden, but also generally results in too great a depth of the ground floor, which it is found hard to utilize.

This difficulty was overcome by an innovation which occurred to me last year. This made it possible for me to satisfy all proper demands and to design plans suitable for all purposes, larger and smaller hospitals, sanatoriums, high-

class apartment houses, five-story tenements and smaller three-story houses, containing six apartments. This innovation consists in a combination of the receding terrace with a balcony projection, the latter having an extension of only one meter, thus causing a platform of two to two and one-half meters, losing only one to one and one-half meters in receding.

As a balcony projection of only one meter curtails the access of light and the circulation of the air so little for the rooms below as practically to be of no importance, while that of only half a meter more would cause a perceptible decrease in both, such a combination not only fulfills all my demands—the open sky above all terraces of the house, since only the smaller part under the balcony is covered, a close connection with each front room and a sufficient width of level egress to roll out beds, and to promenade—but at the same time, does not neglect economic and architectural feasibility.

The eminent value of such living terraces, which will of course be decorated with flowers, will only be fully appreciated in the entirety of its beneficial consequences and its reciprocal action, when the subjective influence of buildings erected according to my plan has been actually felt, and objective results, the health and the efficiency of the tenants, have become obviously increased.

A great portion of this success may be due to the possibility of open air treatment for patients confined to their beds. For these are really more dependent on this sort of treatment than those able to walk.

For very serious fever patients and post-operative patients, the facility of easily moving their beds out into the open air, would be an invaluable and decisive factor in their recovery.

The excellent experience of American physicians, especially that of Dr. Northrup in New York, with open air treatment, for severe cases of pneumonia, gives this method an unusually good outlook. It need scarcely be mentioned that an injurious loss of heat may be easily avoided by wrapping up the body suitably and that continual reliable supervision is imperative.

Dr. Millet, the director of a sanatorium for tuberculosis in Brockton, near Boston, has his patients sleep in their beds at night in an uncovered terrace, viz., under the open sky, since the year 1900, unless rain is expected, and reports surprisingly good results from this method. Likewise the patient who is able to walk about, as well as the person in good health, will sooner be persuaded to indulge in the enjoyment of taking the air, no matter in which story he lives, when the occasion for doing it is put before his nose, so to speak, by the possibility of stepping out of the window at any moment, whenever he chooses, and returning again at will. This is particularly true on days when the weather is changeable, when the sun often only appears for a short time to disappear soon again. It is preferable to get the increased supply of air produced by exercise, from the atmosphere of the terrace, instead of from the day room, which, at its best, can never become an equivalent for out doors.

The only terrace sanatorium in the world is the King Edward VII Sanatorium for Consumptives in Midhurst, which was built seven years ago, according to my plans, submitted for the contest offered by King Edward. This institution, however, only has the simple terraces, such as I suggested originally, without the balcony combination, which not only facilitates the spacing, but also diminishes the cost of construction.

The leading physician of the Sanatorium, Dr. Bardswell, is most enthusiastic over the incomparable superiority of the terraces to the reclining halls ordinarily used.

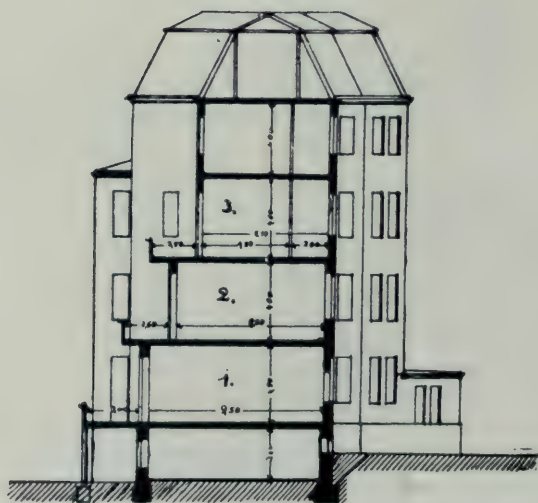
This experience is all the more valuable, as the sanatorium principally receives patients who are able to walk about, and moreover, has extensive gardens. Even under such conditions this proves the terrace system to be an indispensable foundation for therapeutical success.

I wish to add here that it is erroneous to believe that a stay on the terrace is only valuable in summertime and then too only in a relatively favorable climate, so that its efficiency would be lost in unfavorable climates. On the contrary the possibility of immediately retiring into the living room, which the proximity of the two facilitates, permits

one to take the air several times daily even in stormy weather, whereas a continuous stay indoors would otherwise be necessary.

If one considers that an oft repeated, short therapeutical stimulus may not only produce as good results as a more lasting uninterrupted influence, which gradually causes a certain dullness of susceptibility, but may even prove superior when rationally enforced, it will easily be understood that these terraces are still more important in winter and in rough climates than in summer in more favored ones. A protection against loss of heat and strong winds must naturally be provided, as well as against heavy snow-falls. As stated above, the wards themselves represent reclining halls when the glass doors are open.

Besides the reclining cures, another branch of aërotherapeutics has been receiving the attention of scientific circles of late. It is that branch which, I believe, will be



Variantes.

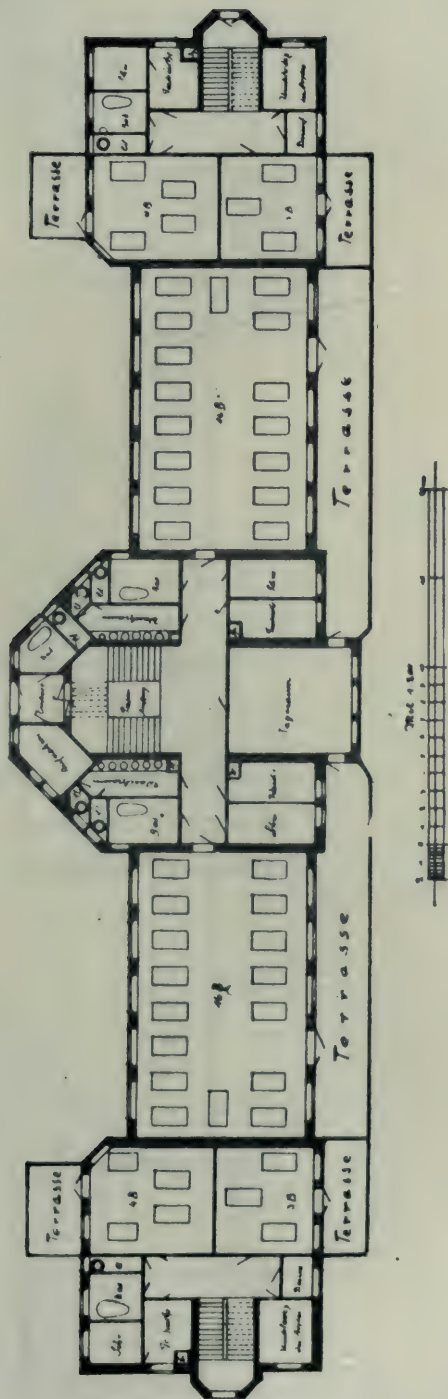
3. *Geophago.*



Variante.
4. Geschoss.



1. Sachsen.



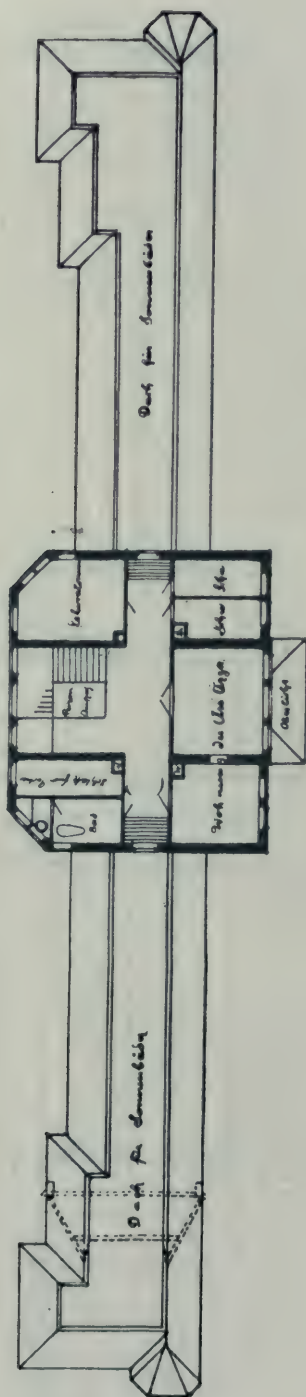
2. Geschoss.



3. Bexhese.



Dachgeschoss



recognized as the most powerful, most adaptable, and most universal remedy of therapeutics and hygiene, namely, air baths.

But in order to popularize this remedial factor, beyond the narrow circle of enthusiasts it is necessary, owing to the hygienic indifference of most people, not so much to make the general public understand its highly hygienic value, but for money to overcome their natural mental lethargy. Its accessibility would have to be facilitated so much as not to cause any special application of energy in making use of the same, at any time, *i. e.*, in other words, the opportunity to take air-baths must be brought into such close proximity to one's residence, as is only possible by my terrace-system. Curtains on the bannisters would serve as a finish for the front, and the possibility of looking down into the lower terraces from the upper ones might be eliminated by giving the balcony railings obtuse angles, although no protection can be furnished against vicious gymnastics.

But there is no doubt that the desire for new advantages and privileges to be derived from living on the terraces, will also create new and severely respected rights.

Next to the fundamental advantages of the terrace system for therapeutics and general hygiene, some architectural advantages, considered solely in the light of architectural hygiene, are deserving of attention. First of all the greater penetration of light and air into the sloping cube of any house, in contrast to the solid cube of other buildings. Then, as a result of this sloping, the increased length of time during which the sun strikes the rooms, with the greater benefit of the sun's warmth, which is not to be undervalued in the winter of a cold climate. It also seems to me that the coolness brought about by evaporation in the summer time, by permanent light sprinkling, should receive attention.

Finally, the terrace system furnishes two further important advantages, namely, great safety in case of fire, since the danger of suffocation is done away with, by the chance of saving one's self on the terrace. This also facilitates the work of the firemen. These are advantages which the late Fire Commissioner of Berlin, Giersberg, praised highly. Another improvement worth mentioning in the

charm of a fine attractive appearance, by which the ascending stoop-like terraces have been transformed into hanging gardens. In the case of a hospital, this would rob the front, which has been furnished with a protruding addition for practical purposes, of its characteristic, matter-of-fact appearance, and would exercise a beneficial influence on the minds of the occupants, so that the thought of living in such a house would unconsciously appeal favorably to them.

I made the assertion before, that with the method I had found for spreading and improving open air cures, a method had been discovered, at the same time, which creates new architectural conditions, by means of which those reasons are rendered inoperative which had been brought against the erection of buildings three and more stories high, as well as against hospital communities of more than eighty persons. I hope you will now admit that I was justified in making such an assertion. For the materially enlarged surface of the additions in contact with the air, owing to the sloping cube of my house, also permits of an almost equally favorable natural exchange of air in three and four-story buildings, as is the case in two-story pavilions having congruent floors. Another feature in favor of this building is the increased penetration of the air and sun into the inner parts, adding to its healthfulness. Furthermore, an important gain is the greatly increased enjoyment of the open air, made available to all the patients without any trouble. Finally, a terrace house is better able to counteract the polluted air which passes from one floor to another inside, by easy and frequent emptyings of the wards out into the terraces, thus enabling the former to become aired properly. This is a most valuable advantage in the summer.

The communication of the indoor air could be still better avoided by following the suggestion of the civil engineer, Mr. Heinrich Berher, who proposed to utilize the favorable terrace-like construction of the floors, by building special stairways to each floor, entirely separated from one another, so that a pavilion might be erected, possessing the advantages of isolating each of the four stories, thus approaching the conditions which ground-story buildings present.

I shall now recapitulate the statement made heretofore into the following demands:

1. Higher buildings for the accommodation of larger hospital communities in order to centralize in a suitable measure, thus lowering the cost both of building and management, as well as making advantageous changes in the management.

2. The terrace system to be used exclusively for these buildings, chiefly to gain the invaluable therapeutic and other advantages, resulting from this style of architecture and, in the second place, to put high-storied pavilions on a par with the two-storied ones usually preferred for architectural hygienic reasons, thus adapting the former to the severest demands. For conditions such as exist in America, where they build up to seven stories high, I should advise that the four lowest stories be built to the terrace system, and the three upper ones placed congruently on the fourth. Then those patients who are able to be about, could be placed in the upper stories, where the roof garden might be utilized for the open air treatment, while the occupants of the four lower floors could use the terraces.

It is my firm conviction, as well as that of a number of eminent professional men, that these demands will dominate the future of hospital architecture, for, as far as architectural plans are concerned, they promise the fulfillment of all they claim both for the social and educational mission of the hospital.

Not being a professional architect, I do not wish to make any more special statements as to the manner of conquering the technical architectural difficulties, which the terrace system presents. I will only say that several expert professionals coincided in declaring that the main difficulty to be overcome is the propping of the receding front walls, which may be done at a relatively slight expense, now that skill in re-enforced concrete work has become so far advanced. On the other hand, the projecting balconies cause a decided reduction of constructive labor, so that the cost of building is materially diminished.

In the second place the lighting of the platform must be considered, and the guards must naturally be made of a suitable light material, and thirdly, a compensating pro-

tection against heat and cold should be provided for the exposed parts of the ceiling in rooms which are under the terraces. Both these problems may be easily and satisfactorily solved, I am told, owing to the wonderful progress that has been made in technical skill. According to the advice of Professor Messbaum, porous pumice-stone is especially adapted for this purpose. This will furnish necessary protection against cold, and, if combined with props of re-enforced concrete, will be found most available for the front walls, as only these and not an entire scaffold of re-enforced concrete, which would carry the sound too much and would also entail a greater expense, will be used.

I should now like to show you some photographs of sketches, made according to the terrace system, of different hospital buildings that contain one hundred beds, and also of a sanatorium (which could also be used as a high-class apartment-house) containing forty-four patients' rooms. This sanatorium, consisting of a high ground floor and four other stories, has been estimated on by the gentleman mentioned before, Heinrich Becher, of the firm of M. Czarnikow & Co., of Berlin, who finds that the price would be a very moderate one, even for ordinary architecture. (I purposely omit the figures, quoted in marks, as of no interest to an American audience.) The reasons for this moderate price of construction are, that the greater expense caused by the sectional sill peculiarities of this method of construction is outweighed by the compensations afforded by the terrace system. In the first place, less expense for roofing, as well as, secondly, for the furnishing of the interior, because its entire area is smaller, thus giving us more room on the outside, and thirdly, thinner front walls such as are needed for one-story buildings, because they have less weight to carry.

The two sketches for one hundred beds each, may be considered as a universal type of hospitals and of sanatoria of all kinds.

Permit me here to mention a point of view, which I had occasion to discuss with the late Professor Von Renvers, who was exceedingly pleased with my terrace system, and who entirely coincided with me in pronouncing the present gigantic hospitals as far too dear. He declared that accord-

ing to his conviction, the maximum number of beds for a hospital should not exceed three hundred, if it is to be economical, as a larger number increases the running expenses too much.

I should therefore advise concentration in ground place of single hospitals, using the terrace system as an aid; local institutions, covering the needs of large cities, to be decentralized by the equal distribution of segregated hospital buildings, for one hundred to three hundred beds, over the whole extent of the city. The advantages would be:

1. Dispensing with expensive central buildings, the central management and everything pertaining to it.

2. Transportation to and from the hospital would become far easier.

3. The possibility of dividing these smaller buildings into special groups of institutions for the treatment of various diseases, as well as for acute cases, for chronic invalids, or for convalescents.

4. The possibility of quickly adding to the hospitals, when necessary.

5. Concentration of the services of the physicians, effecting a gain of beneficial results for the patients, nor would the interest in scientific research have to suffer by this plan.

THE APPROPRIATION OF PUBLIC FUNDS
FOR THE PARTIAL SUPPORT OF
VOLUNTARY HOSPITALS IN
THE UNITED STATES
AND CANADA.

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In the report of the Committee on Hospital Progress presented to this Association at its Ninth Annual Meeting in Chicago in 1907, I called attention to the distinctively American practice of appropriating public funds for the support of hospitals managed by private benevolent corporations. The subject was introduced at that time for the purpose of comparing the relative merits of two of the principal methods followed in making such appropriations, namely, the lump-sum subsidy system, exemplified in the practice of the Commonwealth of Pennsylvania, and the per capita contract system, one form of which exists in the City of New York.

The discussion which followed the publication of the report to which I have referred showed so widespread an interest in the subject that I was prompted to carry somewhat further the investigation thus begun; and I have now undertaken to put together information obtained from various parts of the country in relation to the amounts appropriated by states, cities, counties and towns for the support of dependent patients occupying beds in voluntary hospitals, together with some of the laws, ordinances, rules and regulations governing such appropriations. It will be seen

that very considerable sums of money are involved in these appropriations, and that the subject of our inquiry presents some interesting problems in public administration.

The proper regulation of the appropriation of public funds for private institutional expenditure must be regarded as a desirable object. Public appropriations of any sort are liable to abuse, and the abuse of the particular appropriations with which this study concerns itself may result in many serious evils. For example, it may by simple extravagance lessen the number of patients treated; or it may lower the average efficiency of hospitals by unwisely favoring the development of the least serviceable type of hospital; or, again, it may check the spread of a really useful and desirable form of social co-operation by making it appear to the casual observer that the abuse of the system is inevitable, its proper control and regulation impossible. All of these effects we should endeavor to avoid.

Before directing your attention to the appropriations made by and in the several states, therefore, I shall enumerate the guiding principles which in my opinion should govern and safeguard all appropriations of public moneys for private institutional expenditure. These principles, in the main, are well expressed in a report presented to the Comptroller of the City of New York in 1899 by a Committee of the State Charities Aid Association, as follows:

(a) All institutions and societies should receive the same payment for the same class of inmates;

(b) The city (or state) should make all payments to hospitals at a per capita rate instead of making an appropriation of a gross amount;

(c) The city (or state) should make no appropriations for the maintenance of hospital patients, except such as are accepted as proper public charges after due investigation of the circumstances of such persons by competent official investigators representing the public authority; and the city (or state) should pay for such persons only for such periods of time as are approved by its own medical investigators or examiners;

(d) When the city (or state) maintains institutions of its own for special classes of cases, and these institutions are not filled, the city (or state) should not pay for the same class of patients elsewhere.

Here are indicated the means—(a) to insure equality of treatment for all beneficiary institutions; (b) to establish a simple and honest ratio between work done for the community and money paid by the community; (c) to prevent fraud in the admission of patients, and to discourage the conversion of hospitals into lodging-houses; (d) to avoid unnecessary and wasteful duplication of plant.

To these recommendations I would add that since, in accepting a measure of public support, private hospitals become semi-public institutions, they should be required to make full financial statements to the public authorities, and should be subject, so far as the sanitary and economic aspects of their work are concerned, to official inspection; and that, in order to prevent any undue shifting of responsibility, the city or state should not pay to any private hospital the whole cost of maintaining any one patient, or more than half the cost of maintaining the hospital.

The substance of the recommendations made by the State Charities Aid Association's Committee of 1899, has been incorporated in the rules and regulations under which the City of New York now carries on its admirable system of co-operation with hospitals founded and maintained chiefly by voluntary contributions; and strict adherence to these principles has resulted in a state of affairs so highly favorable to the New York tax-payers that at the last convention of this Association, Dr. Potter, a representative of the Department of Finance of the City of New York, declared that "city authorities everywhere should stimulate the development of private charitable institutions to the extent of the powers given them by law, should make use of such institutions for all possible charitable work, and should develop public hospitals only to supply any gaps in the private hospital system, or for the care of such special cases as can not be suitably handled in private hospitals."

From the standpoint of the humanitarian the object of gratuitous hospital support is the proper care of poor and helpless sick persons; from the standpoint of the tax-payer it is the proper care of such persons *at the minimum public cost*. If, therefore, privately managed hospitals are able

to care for their partially subsidized patients quite as well as such patients are cared for in hospitals supported wholly by public funds (a supposition which I think will be accepted without question), it would seem to be sound civic and business policy for the tax-payer to unite with the private hospital to further the development of the system of financial co-operation which Dr. Potter advocates.

Already, as the present investigation shows, public appropriations for the support of private hospitals are made in thirty-five States, the District of Columbia, and the Provinces of Alberta, Manitoba, New Brunswick, Quebec, Nova Scotia, and Ontario.* The purpose of these appropriations is everywhere the same, namely, to encourage private philanthropic endeavor and thus to lighten the burdens of the local government, which almost everywhere, in English-speaking America, frankly accepts its responsibility for the care of the indigent sick. But for the accomplishment of a single purpose, many methods have been deemed expedient. Some of these methods I shall here briefly mention.

In several States, notably in Pennsylvania, Rhode Island and Connecticut, appropriations are made in lump sum, without any systematic relation between the sum appropriated and the amount or the cost of the work done by the hospitals.

A second method, followed by a considerable number of cities and towns in making their appropriations, is to name a specific sum for the annual support of a given number of beds, granting to the local poor-officers the right to nominate patients for admission to the beds so supported, —a right which may or may not be exercised, or which may be applied to the full limit of the appropriation given to one hospital, while other more favored hospitals are required to earn no more than a small proportion of the sums allotted to them.

*According to the "Report on Benevolent Institutions," issued by the United States Census Bureau in 1904, private hospitals are also subsidized to some extent in five additional states, namely, Colorado, Delaware, Iowa, South Dakota and West Virginia. The accuracy of some of the details of this report, however, would seem to be questionable, for in endeavoring to obtain information concerning the method of appropriation followed in these states, I have received nine letters from hospitals which deny receiving from public sources the sums credited to them by the Census Bureau.

Again, in some States, of which Vermont may be taken as the type, the State law permits towns to appropriate money for the support of private non-sectarian hospitals in a variety of ways, either with or without contract.

In contradistinction to these loose methods is the method which has been most carefully worked out in New York City, according to which the municipal government, at the beginning of the fiscal year, sets aside a certain amount for the benefit of each participating hospital, basing its appropriation upon the facilities of the hospital for the care of public patients, but actually awarding to each hospital, month by month, from the sum set aside for the purpose, only such amounts as are actually earned upon a per capita per diem basis, and requiring that each institution shall open its books and its clinical records to the inspection of city investigators acting under the direction of the Department of Finance and of the Commissioner of Charities.

The conservative and well-ordered system of the Province of Ontario also deserves careful consideration. The peculiar features of the Ontario system are the availability of a moderate per capita allowance for *all classes* of patients during the first ten years of a hospital's existence, irrespective of the amounts contributed by the patients themselves (undoubtedly for the purpose of encouraging the establishment of new hospitals in young communities); the restriction of the provincial allowance, after the first ten years, to patients for whose maintenance less than seventy cents per day is contributed by the patients or their families; and the publication of classified tables of expenditures of all hospitals subject to provincial aid and official inspection.

In the succeeding summary, the States are presented in alphabetical order, followed by the Canadian provinces. I am aware that this report is not wholly complete or satisfactory, but I trust that it will serve to show the desirability of a more thorough and systematic investigation of the subject of State aid.

It is well known that hospital facilities are sadly wanting in certain parts of the country. In many communities the tax-payers recognize the need of hospitals to which the

poor might resort, but hesitate to assume the undivided responsibility for the maintenance of an additional and costly arm of the government; while philanthropists of limited means, however eager to be of service to the needy, are equally reluctant to shoulder financial burdens that loom large and threatening. In every such community an alliance of these two parties should be proposed. It is my belief that the publication of a comprehensive report on this subject, making readily accessible for imitation the best forms of co-operation (for hospital purposes) between municipalities and private philanthropic bodies, would hasten the establishment of hospitals in many places where hospitals are needed. In the meantime, the present study, however imperfect, will nevertheless serve to bring to the notice of those who would champion such an alliance, the encouraging information that what they desire to achieve, is an accomplished and approved fact in hundreds of cities and towns throughout the United States and Canada.

ALABAMA.

There appears to be no special law in Alabama governing appropriations.

The City of Birmingham appropriates \$100 per month for the support of five beds in St. Vincent's Hospital.

Mobile, through its local council, makes an appropriation for the support of the City Hospital at an annual bed rate.

In Selma, the Society of United Charities, when making additions or improvements to its hospital buildings, has been aided from time to time by the County Commission. Prior to 1908 an annual appropriation in lump sum was given to this Society by both the City Council and the County Commission; but on January 1st, 1908, both city and county withdrew their appropriations and the Society was compelled to close its hospital.

ARIZONA.

The territorial law of Arizona allows County Supervisors to contract for the care of the indigent sick. Local hospitals are invited to bid for the care of these patients, and the contract is usually let to the lowest bidder. According to the last report of the Census Bureau, the amount of

public money received in a year by the Mercy Hospital of Prescott, was \$6,704, and by St. Mary's Hospital, of Tucson, was \$463.

ARKANSAS.

Ft. Smith, through its City Council, sets aside a certain amount of money each year to be divided among the three charitable institutions of the city, according to the number of patients cared for and the number of days of treatment given. The amount last appropriated for the benefit of the Bell Point Hospital was \$2,500.

CALIFORNIA.

Los Angeles maintains a county hospital under the control of a Board of County Supervisors, but, nevertheless, under a city ordinance, the city contributes \$150 monthly for the purchase of drug supplies for the free College Dispensary.

CONNECTICUT.

The following appropriations were made by the legislature of the State of Connecticut for the two fiscal years ending September 30th, 1909, for the partial support of hospitals privately managed.

Bridgeport Hospital	\$15,000
Danbury Hospital	10,000
Day-Kimbal Hospital	6,000
Derby Hospital	6,000
General Hospital Society of Connecticut.....	20,000
Grace Hospital	10,000
Greenwich Hospital	4,000
Greenwich General Hospital.....	4,000
Hartford Hospital	20,000
Hartford Anti-Tuberculosis	40,000
Litchfield Co. of Win.....	6,000
Meriden Hospital	6,000
Middlesex Hospital	6,000
New Britain General Hospital.....	10,000
N. H. Anti-Tuberculosis.....	15,000
New London Memorial	10,000
Norwalk Hospital	10,000
St. Francis Hospital.....	20,000
St. Joseph Hospital.....	2,500
St. Mary's Hospital.....	15,000

Stamford Hospital	10,000
Waterbury Hospital	10,000
St. Raphael's Hospital.....	2,500
Additional appropriations for buildings:	
Danbury	35,000
New Britain	5,000
Middlesex	10,000

The amounts appropriated by the State of Connecticut are determined by the Committee on Appropriations of the State Legislature, before whom hospital representatives must appear, and the appropriation is supposed to be based on the needs of each institution and the amount of work which it does. In some instances the private hospitals of Connecticut obtain further public support by arranging with city authorities for the payment of a fixed rate for the support of indigent poor having a domiciliary claim. Thus, Bridgeport allows \$5.00 per week for each "city" patient treated in the wards of the Bridgeport Hospital.

New Britain includes in its city budget an annual appropriation of \$1,000 for the partial support of the New Britain Hospital. The application of this fund is not controlled by any contract.

The situation in Hartford, which has the largest general hospital in the State, is thus described by Dr. W. H. Smith, formerly Medical Superintendent of the Hartford Hospital:

"Until within the last two years the city did not have anything in the way of a City Hospital. There is now an annex to the Alms House which is called the City Hospital, in which the city treats as many cases as possible. There are, of course, many emergency cases, either accident cases or cases in extremis which reach us and which cannot be removed to the City Hospital, and such cases are chargeable to the city, under an opinion rendered by the city attorney. This official holds that the hospital can collect from the city for all cases as mentioned above, if it is found, upon investigation, that they are without means and are probably cases to be cared for by the city. City patients are always investigated by the Department of Public Charity, and if, upon investigation, they find that the patient or some member of the patient's family is in a position to pay, then the city refuses the case. The stigma of pauperism is not fastened upon these cases. In addition to the above class of patients the Hartford Hospital cares for all the contagious cases of the City of Hartford, that is, those that go

to any hospital; and as many of these cases are unable to pay for themselves are cared for at the expense of the city, inasmuch as the city has no other place in which to care for them. We receive no direct annual appropriation from the municipality. The city pays only for services rendered just as individuals do, with the exception that we make the rate \$5 for general hospital cases for the City of Hartford, while charging \$7.00 to private individuals."

DISTRICT OF COLUMBIA.

In 1900 the chaotic condition of the District Charities led to an investigation by a Congressional Committee, and as a result of this investigation a Board of Charities was organized in July of that year. One important change effected by the Board has been a change in reference to government appropriations for the aid of private charities, this change providing that payments to such institutions shall be made under the contract system, in lieu of the old system of lump sum subsidy. The system adopted provides for payment to institutions on a fixed per capita basis, for the care of all persons accepted as public charges, after inquiry by the proper officials. The form of contract made by the Board of Charities with the general hospitals is as follows:

[Copy of contract made by Board of Charities with general hospitals.]

"This agreement made this 30th day of June, 1906, by and between, a corporation duly incorporated by law, party of the first part, and the Board of Charities for the District of Columbia, party of the second part;

"Whereas, the said Board of Charities has been duly created by act of Congress, and its corporate existence for the purposes of this contract is hereby admitted by the said party of the first part;

"And whereas, the president of the said Board of Charities, has been duly authorized by said board to execute this contract on its behalf.

"Witnesseth: That it is hereby agreed by and between the respective parties hereto, as follows:

"That for and in consideration of the services rendered during the year ending June 30th, 1907, in caring for, maintaining, and treating such indigent persons as said party of the second part from time to time shall request, by its written designation and certificate in each case, the said party of the first part shall receive from said

party of the second part, and said party of the second part shall pay to it, the sum of for each full day for each person so cared for, maintained, and treated, upon the written request aforesaid, and for the care, maintenance, and treatment of each and every child that may be born in said hospital to any woman after her reception therein at the request of said party of the second part, the sum of for each full day of such care, maintenance, and treatment; and in the computation of time for payment in each and every case, the day of admission into said hospital shall be counted and the day of discharge therefrom shall be excluded, provided, however, that the amount paid for the entire services aforesaid shall not exceed in the aggregate the amount appropriated by Congress therefor, to wit, the sum of for the aforesaid year; the payments aforesaid shall be made monthly on written statements in such form as may be prescribed by the said party of the second part, and not otherwise.

"In testimony whereof,, the party of the first part, has hereto set its corporate seal, with the signature of its president, and the said Board of Charities, by its president, has signed this contract."

(Name of institution)

Witness:

By.....
(Its president.)

Board of Charities for the District of Columbia.

By.....
(Its president.)

Correct:

.....,
Corporation Counsel.

In connection with the contract system of payment to institutions, a system of investigation as to the dependency of applicants has been organized. As a result of this system of investigation the amount of public money paid for the care of indigent sick in private hospitals with which the Board had contracts decreased in six years, from 1900 to 1906, \$644.20, and this notwithstanding a very considerable increase in the population of the city. In the same period the amounts received by these hospitals for the care of pay patients increased from \$31,448.50 in 1900 to \$63,150.30 in 1906. This increase was attributed by the Board of Charities partly to a growth in the population of the

city and partly to the elimination of abuse. A card-index system of records of all public dependents has been installed by the Board of Charities and the results of investigation are briefly recorded. This record system is always available for reference and enables the Board to keep track of the dependent population, avoiding imposition and eliminating the unworthy.

During the year ending June 30th, 1907, the following named institutions were under contract with the Board of Charities:

Rate of payment under contract.

Freedmen's Hospital.

Adults, \$1.10 per day.

Infants born in institution, \$0.40 per day.

Children under 12 years, \$0.65 per day.

Columbia Hospital for Women.

Adults, \$1.20 per day.

Infants born in institution, \$0.40 per day.

Garfield Memorial Hospital.

Adults, \$1.10 per day.

Infants born in institution, \$0.40 per day.

Homeopathic Hospital.

Adults, \$1.10 per day.

Infants born in institution, \$0.40 per day.

Georgetown University Hospital.

Adults, \$1 per day.

Infants born in institution, \$0.40 per day.

George Washington University Hospital.

Adults, \$1 per day.

Infants born in institution, \$0.40 per day.

Children's Hospital.

\$0.65 per day.

Emergency Hospital.

Ward cases, \$1.20 per day.

Emergency cases, \$0.50 each.

Dispensary cases, \$0.10 per day.

Eastern Dispensary.

Ward cases, \$1.20 per day.

Emergency cases, \$0.50 each.

Dispensary cases, \$0.10 per day.

The aggregate appropriations to twelve general and special hospitals for the year ending June, 1907, were \$173,000. Of this amount \$36,500 was paid to the Washington Asylum Hospital, which is a district government institution, while the balance was paid, mostly under contract, to co-operating institutions not under the control of the District government. The daily average number of free patients treated in these twelve hospitals during the year was 657.

During the following year the amounts paid by the Government to private hospitals under contract, and the relation of these amounts to the income and expenditures of such hospitals, were as follows:

The Appropriation of Public Funds

Hospitals.	Whole Amount Paid Under Contract.	Percentage of Public Income.	Percentage of Private Income (Legacies Excluded).	Total Cost of Maintenance Per Capita Per Annum.	Daily Average Number of Patients.	Daily Average Number of Free Patients.
Freedmen's .....	.....	100.00	.....	\$575.89	141	141
Columbia	\$19,231.20	55.40	44.60	529.61	74	53
Garfield	18,389.40	35.24	64.76	582.11	91	51
National Homeopathic	7,348.40	27.89	72.11	824.04	44	21
Washington University	3,000.00	5.59	94.41	789.32	68	25
Georgetown University	3,000.00	.....	.....	.....	54	19
Children's	13,750.65	52.29	47.71	383.63	65	58
Central Dispensary and Emergency ..	13,277.65	59.74	40.26	.....	25	15
Providence	19,000.00	.....	.....	.....	14	102
Eastern Dispensary and Casualty....	6,500.00	45.98	54.02	.....	..	9

The foregoing figures are taken from reports of the District Board of Charities.

The District Board of Charities is not wholly satisfied with the relations at present existing between the Government and private institutions which are aided by Congressional appropriation; this is shown by the following comments upon the existing system, which appear in a report of the Board printed early in the present year:

"The system of appropriations in aid of the support of private charities which, at the time of the creation of the Board of Charities, had for a long time been in existence, was that of lump appropriations directly made to these charities, and measured not by the usefulness or need of the institutions benefited, but by their influence or persuasion. After the many infirmities of this system had been brought to the attention of the Commissioners of the District of Columbia, and through them to Congress, the contract system was substituted for what might be called the subsidy system, and this contract system is now in force. While the change has been productive of good in many directions, so far as the application of public funds to private institutions is concerned, it does not, in the opinion of this board, meet the exigencies of the situation, and is subject to weaknesses and proper criticism. While all appropriations now made are based upon estimates prepared by the governing boards of these respective charities, and are as carefully revised by the Board of Charities as conditions will permit, the fact that the institutions themselves are not under the control of the Board of Charities makes it impossible for the board to be fully advised as to the accuracy of the same. This absence of authority on the part of these charities to the board make regulation impossible and tend to make our recommendations uncertain, if not misleading.

"A natural desire on the part of these institutions to absorb the entire appropriation is sometimes evident, and each year the Board of Charities is urged to recommend a larger appropriation based upon an annually increasing estimate, and it is apparent that private support and donation are lessened just in proportion to the increase in public appropriation.*

*This does not agree with the experience of private hospitals in New York, where donations and legacies are given quite as freely to hospitals which derive a part of their income from the city as to hospitals which are wholly self-supporting. Where private support fails, the cause is to be found in the apathy of trustees, a condition which may arise in any charitable institution. It is possible, of course, that a loss of the sense of responsibility may result from the adoption of a system which throws on the government the chief burden of support; and it is noteworthy that some of the private hospitals of the District of Columbia derive more than half their income from governmental sources. In these cases it is not the principle of state aid which is at fault, but an unwise application of the principle; for the usefulness of this principle to the tax-paying community requires that the private hospital shall continue to be mainly self-supporting, and demands the proper regulation of public appropriations.

The "remedy" suggested by the Board of Charities would only increase the burdens of the government. A wiser administrative policy would be to reduce and to control rigidly the per capita allowance to private hospitals. The government can well afford to aid such hospitals, but should not undertake wholly to support them—certainly not to supplant them by more expensive public institutions.

"It is also a fact that institutions obtaining congressional aid through contracts with the Board of Charities, at the same time apply directly and through friends to Congress for, and receive, additional appropriations for construction, equipment and repairs, to be expended by their own board and not under the supervision or control of this board or other governmental agency.

"We believe that a remedy for the evil suggested can only come through a more complete equipment and occupation of the field of charitable endeavor in the shape of institutions wholly under the direction of the District government; broad enough in their aims and complete enough in their equipment, to take care of all who should be the object of public charity."

FLORIDA.

Early in 1909 the City of Jacksonville agreed to make an appropriation of \$5,000 per year for the support of dependent patients occupying beds in St. Luke's Hospital. During the year ending March 31st, 1909, 198 free patients were treated in this hospital. The total number of days of free treatment was 3,505, and the average cost per patient per day, \$1.90.

Jacksonville also grants an allowance of 35c per day for each inmate cared for in the so-called County Hospital, which is under the management of a physician, but which is really little more than a poor-house.

GEORGIA.

The City Hospital of Augusta, in charge of the faculty of the Medical College of Georgia, obtains an annual appropriation of \$14,000 for the support of free beds for white patients, \$5,100 of this sum being allowed for the up-keep of the Dispensary. Occasionally additional sums are allowed for repairs or improvements to buildings; the last appropriation for this purpose was \$2,000. Appropriations for buildings and maintenance have also been granted to the Lamar Hospital (colored).

In 1814 Columbus appropriated \$9,000 for construction purposes for the privately managed City hospital. An allowance of 50 cents per day is granted by the municipality to this hospital, for the support of indigent patients.

The total expenses of the Macon Hospital and Dispensary are from \$28,000 to \$30,000 per annum. Of this sum the

hospital receives annually from the City of Macon the sum of \$6,000 to defray the cost of caring for poor City patients sent to the hospital on the order of public officials. In accordance with a legislative act the County gives to the hospital \$5,000 under the same conditions as the City. Neither City nor County has any control over the hospital or its work. The appropriations received bear no defined relation to the total number of public cases cared for, or to the number of days of treatment given.

KANSAS.

Wichita pays to Wichita Hospital and to St. Francis' Hospital \$600 per annum each, in return for which these hospitals undertake to give free treatment to all indigent patients sent to them, including non-residents suffering from accidents.

KENTUCKY.

A City appropriation is granted by the local council of Lexington to the Good Samaritan Hospital and to St. Joseph's Hospital. The grant is of a stated monthly sum; in 1908 the grant to the Good Samaritan Hospital was equivalent to a per capita allowance of about 55 cents per day. The City requires a monthly financial report from each co-operating hospital. Lexington has also aided the two hospitals just named by an appropriation of \$5,000 to each for building purposes. A variable appropriation (but sufficient always to cover the cost of caring for county patients) is made also by the county for the benefit of these hospitals.

State appropriations in Kentucky are confined to State institutions such as insane asylums.

ILLINOIS.

The State makes no provision for the aid of private hospitals which do charitable work, except in so far as exemption from taxation may be regarded as a form of State aid. Under the Illinois taxation law, institutions which are organized for charitable purposes and the property of which is used for such purposes, are exempt from taxation. In 1907, however, the taxing body, known as the Board of

Review, undertook to tax all of the hospitals in Chicago, and from its decision an appeal was taken on behalf of the Provident Hospital. The Supreme Court decided that hospitals which are largely charitable institutions are exempt from taxation. The Board of Review took the position that because private hospitals treated pay patients for revenue, they did not fall within the statutory exemption, and therefore ought to be taxed. The Supreme Court held that institutions which do a large amount of charitable work, and which at the same time treat some patients for money, are exempt from taxation. (The decision of the Supreme Court may be found in Volume 233 of Illinois Reports, page 268.)

Small appropriations are made by a number of Illinois cities for the support of indigent patients in private hospitals. Among such appropriations are the following: Evanston, to the Evanston Hospital, \$350 per annum; Elgin, to the Sherman and St. Joseph Hospitals, each \$300 to \$500 per annum; Aurora, to the City and St. Charles Hospitals, each \$1,500 per annum; Rockford, to the City and St. Anthony's Hospitals, each \$500 per annum; Galesburg Cottage Hospital, \$75.00 per month.

INDIANA.

Terre Haute, through its City Council, makes an appropriation of \$100 per month each for the benefit of St. Anthony's and Union Hospitals.

La Fayette, in 1908, aided St. Elizabeth's Hospital by an appropriation of \$500, and the Home Hospital by a grant of \$300, in both cases for the care of the indigent.

Evansville makes an annual appropriation of \$1,200 each for St. Mary's Hospital and the Deaconess Hospital.

St. Joseph's Hospital, Logansport, receives an annual municipal grant of \$250.

LOUISIANA.

The City of New Orleans allows about \$2,500 per annum to the Touro Infirmary, and \$7,000 to the Eye, Ear, Nose and Throat Hospital.

MAINE.

Twenty private hospitals in the State of Maine are partially supported by public appropriations. There is no general law regulating such appropriations; the Legislature, after a hearing in Committee, passes a "resolve" in favor of such hospitals as are considered worthy of assistance, granting to each hospital such sum as is thought advisable.

A State appropriation, usually amounting to \$5,000 per annum, is granted to the Eastern Maine General Hospital, at Bangor, and a like appropriation to the Central Maine General Hospital, at Lewiston. From time to time additional sums have also been granted to the latter hospital by the State, for building improvements.

The Maine General Hospital, at Portland, which in 1906-7 spent \$30,000 for the maintenance of free beds, obtained from the State an appropriation of \$8,500. This hospital has obtained no State appropriation for building purposes since 1896, when \$2,500 was granted.

MARYLAND.

Liberal grants are made by the State of Maryland to private charitable institutions. The Board of State Aid and Charities requires every institution in the State receiving State aid to present, six months before the meeting of the Legislature, a tabulated list of needs. Blank forms are furnished by the secretary of the board calling for specific and detailed information as to all the uses to be made of the money. These inquiries cover numbers fed; number of employees, specific service of each, and amount of salary; expenses for support, for repairs, improvements, etc. These blank forms, properly filled, are returned to the board before July 1st. The Legislature meets January 1st following. At an appointed time in the fall a hearing is given to representatives of the institutions in question and the application previously filed is made the basis of conference and inquiry.

Notwithstanding its insistence on these preliminaries, the Maryland Board of State Aid and Charities has been criticised for its failure to make thorough investigations of the work of institutions to which appropriations are given on

the recommendation of the Board. In a letter to "Charities" commenting on the situation in Maryland, John M. Glenn, Director of the Russell Sage Foundation, wrote as follows:

"It is impossible to understand the work of an institution or get any real idea of its standards except by personal inspection. Information sent on blanks amounts to very little and is often misleading. If the board has relied chiefly on tabulated forms it has certainly not carried out the spirit of the law and, if my recollection is right, it has not even carried out the letter, for I think that the law specifically provides that the board shall investigate the institutions on whose appropriations it passes.

"Under the present charter of Baltimore city the Board of Supervisors of City Charities is required to inspect institutions which receive money from the city on a *per capita basis* for inmates sent to them by the city. This board makes regular and frequent inspections of all institutions with which it has to deal. The state should be just as careful in its dealings with institutions."

The total amount which the Maryland Board was asked to give to charitable institutions for the years 1907-8 was \$2,052,600. The appropriations recommended by the Board represented a total amount of \$1,661,600, and the appropriations actually granted by the General Assembly to private institutions amounted to \$1,707,879. It will be seen, therefore, that the legislative appropriations were only \$46,000 in excess of the appropriations recommended by the Board of State Aid and Charities. In the face of large demands and urgent solicitation, the legislature adhered closely to the recommendations of its official advisers.

Among the appropriations to charitable institutions made by the State of Maryland for the years 1907-8 were the following grants to hospitals, clinics and dispensaries:

<i>Institutions.</i>	<i>Per Annum.</i>
Maryland Tuberculosis Clinic.....	\$50,000
Lying-in Hospital	3,000
Nursery & Child's Hospital.....	2,500
Hebrew Hospital and Asylum Assn.....	4,000
Home for Incurables.....	2,500
Hospital Women of Maryland.....	4,000
Baltimore City Hospital.....	10,000
St. Agnes Hospital	3,000
Maryland General Hospital.....	5,000

Hospital for Crippled and Deformed Children..	5,000
Maryland Homeopathic Hospital.....	5,000
Provident General Hospital.....	1,500
Maryland Lyin-In Hospital.....	3,000
Peninsula General Hospital.....	7,500
United Charities Hospital.....	11,500
St. Joseph's Hospital.....	7,500
Franklin Square Hospital.....	6,000
Johns Hopkins University.....	25,000
Baltimore Eye, Ear, etc., Hosp.....	5,000
Frederick City Hospital.....	5,000
Northeastern Dispensary.....	1,000
Annapolis Emergency Hospital.....	3,500
Southern Dispensary.....	500
Washington County Hospital.....	8,500
West End Maternity.....	1,500
Union Protestant Infirmary.....	7,500
Good Samaritan Hospital.....	1,500
Emergency Hospital, Frederick.....	1,200
Union Hospital, Cecil Co.....	2,500
Springfield Hospital.....	71,500
Crisfield Marine Hospital.....	1,250
So. Baltimore Eye & Ear Infirmary.....	1,250
St. Luke's Hospital.....	2,000

MASSACHUSETTS.

In Massachusetts public co-operation with private hospitals and charitable institutions is found in three forms; first, in the form of exemption from taxation granted by the State to charitable institutions; second, under a State law which permits cities and towns to pay private hospitals for the care of persons who are proper public charges; and third, in the form of State appropriations made directly to special institutions.

The Massachusetts law forbids cities and towns to make direct appropriations of money to private hospitals (although the State itself makes some such appropriations), and requires that all money given by cities and towns to such institutions must be expended through the local Overseer of the Poor. Thus, the Somerville Hospital receives from the Overseer of the Poor an appropriation of \$5,000 per annum, in return for which the Hospital takes care of

all City cases sent to it by the poor officers. The charter of the City of Somerville contains the following provision:

"The Board of Aldermen may appropriate money from time to time in aid of the Somerville Hospital, and in return for such appropriation may arrange for the care of such city patients as can be received at the hospital, but such appropriation shall not exceed in any one year a sum amounting to one one-hundredth of one per cent of the assessed valuation of taxable property of the city for the preceding year."

Other private hospitals in Massachusetts which are aided by municipal appropriations expended under the direction of the poor officers are the following:

<i>City and Hospital.</i>	<i>Appropriation.</i>
New Bedford—St. Luke's....	For each approved case \$5.00 per week
Malden—Malden	For each approved case, \$10.00 per week
Newburyport—Anna Jaques.....	For one bed, \$600.00 per annum
Brockton—Brockton	\$2,500.00 per annum
Everett—Whidden Memorial..	For each approved case \$7.00 per week
Gloucester—Addison Gilbert..	For each approved case \$7.00 per week
Northampton—Cooley Dickinson.	For each ap'ved case \$7.00 per week
Fitchburg—Burbank..	As a temporary maintenance fund (until the full foundation bequest shall become available), \$15,000.

Waltham makes a contract every three years with the corporation of the Waltham Hospital. Under the contract dated July, 1908, the city pays \$10.00 per week for medical and surgical cases, and \$14.00 for diphtheria and scarlet fever cases. The Mayor of the city and other public officials are seated on the Hospital Board of Trustees.

For the past fifty years, the Massachusetts Charitable Eye and Ear Infirmary has received an annual contribution of money from the State of Massachusetts. The State's contribution has been usually about one-third of the annual cost of maintenance. In addition to this, the State eleven years ago gave the institution one hundred thousand dollars to help pay the cost of new buildings. Two members of the Infirmary's Board of Trustees are appointed by the Governor annually. The special help given to this institution is explained by the fact that from its foundation the institution has taken care of large numbers of the poor from all parts of the State. It admits all cases sent by

State institutions, and maintains a special building for the treatment of gonorrheal ophthalmia, thereby saving a large amount of money to the Commonwealth and the Community.

Massachusetts requires all private charitable institutions whose personal property is exempt from taxation to make annual returns to the State Board of Charity. In 1907, 469 charitable corporations made such returns. Their total valuation was \$49,775,437.89, including (a) property owned and occupied for corporate purposes, \$21,299,496.24; and (b) investments, \$28,476,941.63. The whole number of beneficiaries reported was 539,757 (besides 5,176 families), of whom over 270,000 were aided free, the remainder either paying or partly paying for the service rendered. At a total expense of between six and seven million dollars, about 300,000 persons received charitable aid from these several corporations, in addition to nearly as many more who partly paid for the service rendered them. Nearly \$30,000,000 of personal property was exempted from taxation on the ground that the corporations in question were dispensers of charity.

The Boston City Hospital, although a municipal institution, nevertheless receives a certain amount of money from the Commonwealth of Massachusetts. The money is obtained through the Overseers of the Poor at Boston, who collect from the Commonwealth money for the board of persons in the Boston City Hospital who have no legal settlement in any city or town. The Overseers of the Poor employ clerks to look up the settlement of patients and to render bills for their care to such cities or towns as may be found to be legally responsible.

MICHIGAN.

The following statement describing the system under which private hospitals in Detroit obtain money from municipal, county or state sources, was kindly prepared by Dr. W. L. Babcock, of the Grace Hospital:

"City cases are received on the order of the City Poor Commissioner and seven city physicians. The City of Detroit pays \$6.00 per week for the care of city patients. This rate applies to general medical and surgical cases only. The treatment and care of these

patients is confined to the Attending Medical and Surgical Staff of the Hospital, and the patients are available for clinical teaching.

"County patients. These are received from various counties in Michigan at the same rate as medical cases, and at the rate of \$8.00 per week for surgical cases. The bills are paid by the county Superintendents of the Poor.

"Cases of contagious disease are received in one of the Detroit hospitals, on the order of the City Board of Health. Payment is made by the Board of Health, at the rate of \$14.00 per week.

"The City of Detroit pays one of the hospitals of the city at a rate ranging from \$8.00 to \$12.00 per week, for the care of cases of *delirium tremens* and *mental disease*. Mental cases are only cared for temporarily, pending commitment to institutions.

"Patients brought to the hospitals by the police, or sent in by the police department are rated as city patients at the regular city rate.

"City employees, notably members of the police, fire, water or lighting departments, if taken ill or injured while at work, are sent to the various hospitals of the city and received at the regular hospital rate for wards and private rooms. Bills are paid by the department employing the patient.

"There are no regular appropriations to private charities made by the State Legislature. Special appropriations may be made by the legislature to certain charities, but general or private hospitals have never been included in such appropriations. In fact, appropriations of this character are almost unknown in Michigan. The State maintains various charitable institutions, notably for the insane, blind, feeble-minded, crippled, orphans, etc., for which regular appropriations are made."

The Lansing Hospital is aided by a municipal appropriation of \$1,500 per annum for the support of city patients. The hospital's ward-beds are all, if needed, available for this class of patients.

MINNESOTA.

Winona supports one bed for indigent patients in the Winona General Hospital, for which the sum of \$800 per annum is appropriated.

Stillwater, which owns the \$15,000 building occupied by the Stillwater Hospital, leases the building without price to the hospital corporation, and contributes in addition \$1,500 per annum for repairs.

MISSOURI.

Dr. Wayne Smith, of the Washington University Hospital, writes that "the State law (i.e., of Missouri) forbids the use of public money for hospitals privately managed." Dr. Smith presumably refers to a prohibition which applies to the funds of the State itself, for municipal appropriations in aid of private hospitals are reported by Hannibal, which city gives to the Levering Hospital a sum not exceeding \$2,400 in any one year, and by St. Joseph, which city contracts to pay to St. Joseph's Hospital \$5.00 per week for each city patient.

NEBRASKA.

The South Omaha Hospital receives from the city of South Omaha, without contract, \$100 per month for maintenance.

NEW HAMPSHIRE.

Nashua appropriates \$2,500 per annum for the partial support of the Nashua Emergency Hospital. All city patients, without numerical limitation, are thus entitled to free hospital treatment. The Mayor of the City and President of the Common Council are ex-officio members of the Board of Trustees of the Hospital.

The Martha Pillsbury Hospital obtains from the City of Concord \$2,000 yearly for general support. The hospital maintains 50 beds, and is largely self-supporting.

NEW MEXICO.

By a special tax, Albuquerque raises \$600 per annum for the support of charity patients occupying beds in St. Joseph's Hospital.

NEW JERSEY.

I am indebted to Mr. Samuel Huntington, Chairman of the Managing Committee of the Muhlenberg Hospital, Plainfield, for the following report on the law and custom of New Jersey:

"A statute in New Jersey authorizes cities in the class with Plainfield, having no city hospital, to levy a special tax to be applied to payment of hospital charges against persons placed in the

hospital by the city officers. Under this act the Muhlenberg Hospital has made a contract with the city to receive and care for **such patients** as may be sent to it by certain city officers during the present year (1908) for the gross sum of \$1500, payable at or about the end of the year. This contract was made with the city in accordance with a vote of the Common Council.

"There is also a considerable amount of money raised by taxation in Union County for the support of hospitals, under an act of the legislature. The amount so raised is apportioned among the different hospitals in the county by the Board of Chosen Freeholders, which is the governing body in county affairs. Our hospital received from this source about \$5,000 last year. We receive nothing from the State of New Jersey, and I think there is no law by which the State is authorized to pay anything for the support of private hospitals, or of patients in them.

"The gross sum I have mentioned as paid by the city is not based upon the number of public cases cared for, nor upon the number of "hospital days." If it were, the hospital would probably require all patients living in Plainfield, who could not pay for their treatment at the usual rates, to be sent to the hospital by the proper city officials; and in that case the charges against them would far exceed the present appropriation by the city. I have the impression that the apportionment of hospital money by the Board of Chosen Freeholders is made approximately in proportion to the whole number of "hospital days" in the different hospitals in the county."

In Newark, appropriations for the benefit of private hospitals which accept City patients are made at the rate of \$250 per bed per annum. These appropriations are made by the Common Council upon the recommendation of its Finance Committee. In practice the amount of the appropriation bears no relation to the amount of City work or free work actually done. One hospital, having ten "City" beds may have its beds constantly occupied by patients who are legally public charges, while another having the same number of "City" beds, and receiving the same annual subsidy, may only occasionally be asked to care for a City case.

A small allowance is obtained from Passaic by the Passaic General Hospital for each patient referred to the hospital by the City Poor Master. Public appropriations applicable to the support of private hospitals elsewhere in New Jersey are named in the following list:

<i>City.</i>	<i>Hospital.</i>	<i>Appropriation.</i>
Perth Amboy.....	Perth Amboy General.	\$5.00 to \$1200 yearly.
Town of W. Hoboken.	Bayonne General....	\$9,000.
Town of W. Hoboken.	St. Mary's (Hoboken)	\$100 yearly.
Town of W. Hoboken.	Christ's (Jersey City)	\$100 yearly.
East Orange.....	North Hudson.....	\$100 yearly.
East Orange.....	General Memorial ..	\$10 per week per patient.
East Orange.....	St. Mary's.....	\$10 per week per patient.
Elizabeth	Elizabeth General.	\$8,000 yearly.
Elizabeth	St. Elizabeth's.....	\$4,000 yearly.
Elizabeth.....	Alexian Brothers' ...	\$4,000 yearly.
NEW YORK.		

In New York, the State Constitution provides that

"Payments by counties, cities, towns and villages to charitable eleemosynary, correctional and reformatory institutions, wholly or partly under private control, for care, support and maintenance, may be authorized, but shall not be required by the Legislature. No such payments shall be made for any inmate of such institutions who is not received and retained therein pursuant to rules established by the State Board of Charities.

Under the State Charities Law, the State Board of Charities is required to establish rules "for the reception and retention of inmates of all institutions which are subject to its supervision," and "to collect statistical information in respect to the property, receipts and expenditures of all institutions, societies and associations subject to its supervision, and the number and condition of the inmates thereof, and of the poor receiving public relief."

In accordance with the law, the State Board of Charities has adopted certain rules for the reception and retention of inmates of institutions under private control, for whose care, support and maintenance payments by any county, city, town or village may be authorized. These rules specify the classes of persons which may be received in such institutions as public charges, and so far as hospitals are concerned, do not permit payments to be made toward the support of inmates, except "with the approval of the Superintendent of the Poor of a county, Overseer of the Poor of a town, or Commissioner of Charities, or other local officer on Board legally exercising the power of the Overseer of the Poor in the county, city, town or village sought to be charged with the support of such persons."

In regard to the retention of inmates, the State Board of Charities requires that

"no adult inmate of any such institution, who has been placed or permitted to remain therein by a proper officer, shall be retained therein at *public expense*, after a date fixed by a commissioner, resident in the District in which the institution is situated, and of which the proper authorities or superintendent or officer in charge thereof has been notified in writing."

The Board furthermore insists upon the humane treatment of all public charges in private institutions, upon compliance by such institutions with the Sanitary Code or other laws or ordinances affecting the health and safety of inmates, and upon the presentation of a detailed annual report, giving a full account of investments, receipts and expenditures. Its rules in regard to these matters are as follows:

"No payment shall be made by any county, city, town or village to any charitable, eleemosynary, correctional or reformatory institution wholly or partly under private control, for care, support or maintenance, which shall fail within a reasonable time after notice to comply:

1st. With any law affecting the health of the inhabitants of said county, city, town or village.

2nd. With any rules or regulation of the local board of health passed pursuant to law.

3rd. With any law regulating the erection of the building of said institutions, or

4th. With any law, or rules or regulations made pursuant to such law, enacted to protect the inmates thereof from fire, or requiring the erection of fire escapes or additional means of egress.

"The inmates of all charitable, correctional or reformatory institutions, wholly or partly under private control, who are retained as a charge upon any county, city, town or village, shall be humanely and suitably provided with food, lodging and clothing and whatever further may be necessary for their safety, reasonable comfort and well-being.

"Each and every charitable, eleemosynary, correctional and reformatory institution, wholly or partly under private control, whether incorporated or not incorporated, subject to the visitation of the State Board of Charities, pursuant to Article VIII, Section 11 of the Constitution, shall, on or before the first day of November in each and every year, prepare and file with the

Board, at its office in the Capitol at Albany, a report of the condition of the institution and its operations, for the preceding fiscal year ending September 30th, upon forms prescribed and furnished for the purpose, to wit:

"1st. The estimated value of the real and personal property of the institution and its assets and liabilities October 1st.

"2nd. The total amount and sources of the receipts of the institution and its total and classified expenditures for the fiscal year ending September 30th.

"3rd. The whole number of persons supported in the institution and the changes in the population during the fiscal year ending September 30th, and the number and sex of those in its custody and care October 1st, with such other particulars as may, from time to time, be required by the Board."

In the City of New York there exists a most effective double check on municipal grants to private hospitals, owing to the fact that appropriations made by the local Board of Estimates and Apportionment under restrictive rules of its own, must be subsequently approved, item for item and patient for patient, by the Commissioner of Charities, acting under the State law as the local Superintendent of the Poor.

The Charter of the City of New York, Section 30, Paragraph 24, contains the following provisions:

The Board of Estimate and Apportionment may in its discretion appropriate to any charitable institution wholly or partly under private control, for the care, support and maintenance of its inmates; such payments to be made only for such inmates as are received and retained therein pursuant to the rules established by the State Board of Charities.

No appropriation shall be made under this section to any corporation unless the Mayor of the City or the President of the Borough be notified of all meetings of its Boards of Management, and be empowered to attend the same or designate in writing the person to do so in his behalf.*

Under the rules of the Board of Estimate and Apportionment all appropriations for charitable institutions in the City of New York are made subject to the following conditions:

(a) The accounts of all charitable institutions receiving public moneys must be so kept as to show receipts and disbursements

*These City officials, however, rarely, if ever, attend such meetings.

in such form as shall be satisfactory to the Comptroller, showing the addresses of the parents, guardians or nearest relatives of inmates, and other information designed to facilitate inquiry into their financial inability to provide for such inmates.

(b) All institutions receiving public moneys must be at all reasonable times open to the visitation and inspection of duly authorized representatives of the Department of Public Charities and the Department of Finance.

(c) Where appropriations are made upon a per capita basis, no payment shall be made for inmates of private charitable institutions unless the same shall have been accepted by the Commissioner of the Department of Public Charities as a proper charge against the city, and, except in emergency cases, the Commissioner of Charities shall not accept as proper charges against the city inmates capable of paying for their own support, or for whose care adequate provision can be made in public institutions. The city shall not become liable for any payment to a charitable institution in excess of the appropriation which may have been made to such institution, notwithstanding any per capita rates of payment that may have been fixed for the inmates thereof.

(d) All institutions receiving money from the city are required to state specifically the amount so received, as from the City Treasurer, in their printed annual reports.

(e) No money may be paid to any private charitable institution which pays any salary to or gives any consideration, financial or of any kind, for services to, or that has any business dealing with, or secure goods or merchandise, directly or indirectly, from any officer or trustee or member of its Board of Managers.

(f) Where the city is paying 50 per cent and upwards of the cost of maintenance of an institution, the Board of Estimate and Apportionment requires representation in the board meeting of that institution, with the right of taking part in all business transactions.

(g) The rates of payments to private charitable institutions, unless otherwise specially provided for, are fixed for the year 1909 for the various classes of hospital inmates as follows:

For infants under two years of age, and in infants' hospitals	
also between the ages of two and five, per day.....	\$ 0.45
For maternity cases, per case	18.00
To hospitals for medical treatment, per day.....	1.00
To hospitals for surgical treatment, per day.....	1.10
To hospitals conducted exclusively for consumptives.....	.80
To hospitals and homes for the chronic incurable or infirm,	
per day .....	.40

The Chief Examiner of Accounts of Institutions in the Department of Finance of the City of New York, in a report prepared in 1907 for the guidance of the Board of Estimate in its consideration of the City Budget for the ensuing year, showed that during the year 1906 over 33,000 patients were maintained in private hospitals at the expense of the City of New York, with the approval of the Commissioner of Charities. These patients were classified as follows:

Medical Patients	11,853
Surgical Patients	14,324
Nursing Mothers	1,440
Chronic Patients	656
Consumptives	3,117
Maternity Cases	1,372

The total number of days' treatment given to these patients was 997,827. The real and personal property of the hospitals with which the City co-operated in the care of these patients, was valued in 1906 at approximately \$17,000,000; the total expenditures of the hospitals for the year was more than three times the amount of the public appropriations received by them.

On January 1st, 1907, according to the Bureau of Charitable Institutions of the Department of Finance, there were 10,436 beds in private hospitals at the disposal of the City of New York, for the care of dependent cases. The public hospitals of the city on the same date had a capacity of 3,894 patients, distributed as follows:

Bellevue	1,054
Fordham	150
Harlem	150
Gouverneur	100
Metropolitan	1,087
City	632
Kings County	545
Cumberland Street	175
Coney Island	21

In 1906 Bellevue and Allied Hospitals, one branch of the municipal hospital service, gave 353,907 days of hospital treatment at a cost to the city of \$612,604. (Certain minor expenditures for maintenance are omitted, owing to book-

keeping complications arising from the relations of Bellevue and Allied Hospitals to other departments). In the hospitals of the Department of Public Charities, the second branch of the municipal service, 898,040 days of hospital treatment were given at a cost of \$798,172. On the other hand, 997,827 days of treatment were given to dependent cases at the city's expense in private hospitals, at a cost to the city of \$699,024. In comparing these figures, it must be borne in mind that in the operation of the municipal institutions the cost of plant must be added to the maintenance cost given, whereas the private hospitals furnished their own plant, without any charge upon the tax-payers.

The municipal hospitals of New York are by no means extravagantly managed; and if the care of indigent patients in these institutions costs the city more than does the care of similar cases in private hospitals, it is because the latter receive from the city only a part of the cost of maintenance. The following table shows that private hospitals which accept the aid of the City of New York are far from assuming an attitude of dependency. In most cases the income which the hospitals derive from public sources represents but a small fraction of their total expenses; and while the availability of such income does not, apparently, lessen the efforts of the hospitals to seek, or their success in obtaining, support from private charitable sources, it nevertheless encourages the hospitals to plan their work upon a more generous scale than would otherwise be regarded by their directors as safe or reasonable. Each additional hospital bed which, by the encouragement of private giving, is made available for a City patient, represents a saving to the tax-payers of about \$4,000 (the cost of modern hospital construction per bed in New York City), plus whatever part of the maintenance cost may be provided, from year to year, by private philanthropy:

Statement of the Expenditures and Work of 22 Hospitals Connected With the Hospital Saturday and Sunday Association of New York City, for the Year Ending September 30th, 1907, Showing the Large Excess of Expenses Over the Income Derived from Public Appropriations.

Names of Hospitals.	Total Expenses of Hospital and Dispensary.	Amount Received from City, County or State Appropriations.	Total Number of Days of Hospital Care for the Year.	Number of Days of Hospital Care for Free Patients for the Year.
Mount Sinai	\$384,319.09	\$54,808.10	137,834	102,465
Lebanon	83,713.69	21,957.04	81,935	52,001
Lying-In	139,895.30	17,379.82	50,225	47,350
Post-Graduate	189,936.11	16,219.95	63,814	45,998
German	172,694.03	17,898.77	71,633	43,925
Ruptured and Crippled	90,970.86	24,831.31	72,765	39,925
New York Infants' Asylum	95,771.00	69,807.38	210,460	35,500
Mothers' Home of the Sisters of Misericordia....	29,250.46	5,111.05	38,519	33,994
Lincoln	151,411.18	62,763.37	88,965	29,681
Nursery and Child's	46,964.37	5,570.87	66,053	29,183
Beth Israel	107,501.31	27,752.25	44,093	27,597
Sloane Maternity	51,322.06	10,918.07	34,116	15,986
Babies'	40,530.73	6,407.86	19,041	14,738
New York Ophthalmic	50,991.91	7,858.68	19,520	12,941
St. Mark's	59,131.30	1,191.94	25,573	12,360
Homeopathic College	55,524.39	6,485.41	25,985	11,386
J. Hood Wright	42,739.93	9,112.12	15,425	10,384
N. Y. Polyclinic	67,072.67	3,059.53	22,452	9,867
Sydenham	47,407.53	5,939.51	19,706	6,634
St. Gregory's	21,228.68	2,055.25	6,568	5,419
N. Y. Infirmary for Women and Children.....	40,527.71	1,784.21	4,743	2,280
New York Eye and Ear	108,055.55	7,481.33	33,806	1,640

Outside of New York City, the New York State law which authorizes cities to co-operate with private hospitals in the care of the indigent sick, has been taken advantage of in Albany, Buffalo, and elsewhere, as shown below.

In Albany, there are three general hospitals, namely, St. Peter's, the Homeopathic and the Albany Hospital; and prior to 1908 the city annually appropriated \$8,000 to St. Peter's, \$4,000 to the Homeopathic, and \$8,000 to the Albany Hospital, each hospital agreeing to take all of the cases sent to it for hospital treatment by the Overseer of the Poor, at the rate of \$5.00 per week. When the sum of money appropriated was exhausted the hospitals agreed to care for additional city cases gratis. In 1908 the appropriation for the three hospitals was raised from \$20,000 to \$23,000, and the weekly rate was changed to \$6,000. At the same time a movement was begun to induce the city to make its further appropriations on a weekly basis of \$7.00.

In Buffalo, private hospitals receive cases sent to them by the authorities of the City of Buffalo and of the County of Erie, there being no regular city or county hospital. Private hospitals receive \$5.00 per week for each case chargeable against the city or county. In 1907, the Buffalo General Hospital received from the city about \$12,000 for the treatment of such cases, and from the county about \$5,000.

Other cities which send their poor to private hospitals for medical or surgical treatment pay for such treatment the sums or rates named in the accompanying table:

City.	Hospital.	Annual Appropriation.	Weekly Rate.
Cohoes	Cohoes .....	....	\$ 6.00
Niagara Falls ...	Memorial .....	....	7.00
Yonkers	(Apportioned among 3 local hospitals)	\$8,000	....
Schenectady	Ellis	6,000	....
Dunkirk	Brooks	1,500	....
Kingston	Kingston City	4,500	....
Newburgh	St. Luke's	2,000	....
New Rochelle ...	New Rochelle	2,500	....
Mount Vernon ...	Mount Vernon	5,000	....
Gloversville	Nathan Littauer .....	....	5.00
Troy	(Apportioned among 4 hos- pitals)	20,000	6.00
Rochester	Rochester City .....	....	7.00
Middletown	Thrall	2,500	10.50

NORTH CAROLINA.

By special enactment, the legislature of North Carolina appropriates \$12,000 per year for the support of the Parker Memorial Hospital at Wilmington. In 1907, 10,137 days of treatment were given to charity cases by this institution.

Raleigh, from its general funds, allows \$2,000 to St. Luke's Hospital, to be expended for charity work.

The Mission Hospital, at Asheville, receives from public sources \$1,800 per annum; half of this sum is donated by the city, the remainder by the county.

The James Walker Memorial Hospital, at Wilmington, receives from the city \$4,800 per annum, from the county, \$7,200. Indigent patients are admitted on the order of the city or the county physician.

The City of Charlotte makes no specific appropriations for hospitals, but pays for the maintenance of patients sent by the city to the three local private hospitals.

OHIO.

In Ohio, all municipal corporations having a population of five thousand or more are classified, under a state law, as cities; those having a population of less than five thousand are classified as villages. Among the general powers granted by the state to both classes of municipalities are the following:

To provide for the public health, to secure the inhabitants of the corporation from the evils of contagious, malignant, and infectious diseases, and to erect, maintain and regulate pest houses, hospitals and infirmaries.

To provide for the rent and compensation for the use of any existing free public hospital established and managed by a private corporation or association organized for that purpose.

The City of Dayton stipulates that private hospitals which are aided by the city shall make a public statement at least once each year. A strict interpretation of this ordinance would bar from participation those ecclesiastical hospitals which make no public financial statement, but in Dayton the law has been liberally construed; an appropriation, equal to one mill on the tax valuation, is divided by the city council between two local hospitals. One of these

hospitals, the Miami County Hospital, also receives a small annual appropriation from the County Poor Fund.

The East Liverpool City Hospital is aided by funds raised by taxation under the state law. The tax levy for this purpose in 1908 was 65/100 mill, yielding \$3,500. The city requires from the hospital an annual financial report.

Other public appropriations made annually in Ohio for the support of voluntary hospitals are voted as follows: By the City of Hamilton, for the Mercy Hospital, \$6,700; by the City of Mansfield, for the Emergency Hospital, \$3,500; by the City of Sandusky, for the Providence Hospital, \$1,600.

OKLAHOMA.

The Oklahoma City is under contract with the Sisters of St. Francis, who conduct a well-equipped hospital, to pay a flat rate for each patient nominated by the city poor officers. The contract provides that the city may use in this way as many as fifty beds.

OREGON.

The County Commissioners of Clatsop County are empowered to contract with St. Mary's Hospital, at Astoria, the county seat, for the care of dependent patients at so much per person.

Portland settles monthly, at the rate of \$1.00 per patient per day, for all city patients cared for in the local private hospitals.

PENNSYLVANIA.

The act creating a State Board of Public Charities adopted in 1869 by the State Legislature of Pennsylvania declare that

"All institutions now receiving, or that may hereafter desire to receive State aid, shall annually give notice to said General Agent, (i. e. of the State Board of Charities) on or before the first day of November, in each year, of the amount of any application for State aid they may propose to make, and of the several purposes to which said aid, if granted, is to be applied.

Whenever any such institutions shall thus give notice of asking for State aid, the General Agent shall inquire carefully into the

ground of such request, the purpose or purposes for which the aid is asked, the amount which shall be required, and into any matters connected therewith; and in the annual report, the result of such inquiries shall be given, together with the opinions and conclusions of the Board thereon."

The Pennsylvania law requires, therefore, (1) formal application for aid, and (2) an inquiry and report by the general agent of the State Board of Public Charities, as preliminaries to any appropriation by the legislature for the support of a charitable institution.

For the years 1903 and 1904 (appropriations being made for two years at a time) the legislature, upon the recommendation of the Board of Public Charities, set aside for the support of 176 private charitable institutions the sum of \$4,657,000, equal to \$2,328,500 per year. In 1905 and 1906 the sum of \$4,142,550 was appropriated for the support of private charitable institutions, of which sum \$3,717,000 was for hospitals. The report of the Board of Charities, published early in 1907, shows that private hospitals applied for no less than \$9,994,000 of public money to be expended by them during the years 1907 and 1908, \$4,396,000 being demanded for maintenance, and \$5,598,000 for building purposes. The appropriations recommended by the State Board of Charities for this period for private hospital purposes were, for maintenance, \$2,943,500, and for buildings, \$1,617,500, or \$4,561,000 in all.

Pennsylvania's appropriations are supposed to bear some relation to the needs of the institutions benefited, and to be proportioned to the amount of charitable work done by such institutions; but there is no rule for the guidance of the State Board and the legislative committee which finally reviews and passes upon the recommendations of the board, is not bound to follow the latter's suggestions. Each act carrying with it an appropriation, is a law unto itself, and specifies the manner in which the money is to be expended.

In an analysis previously published I showed that the greatest irregularities existed in the distribution of public funds to the hospitals of Pennsylvania. The following figures were taken from the reports of four Pennsylvania hospitals chosen at random:

	Total days Free Treat- ment of Ward Patients.	Estimated Cost of Treating Free Patients.	State Appro- priation for Maintenance for the Year.	State Allow- ance Figures upon a per capita per diem basis.
Hospital A.	20,590	\$48,930	\$37,500	\$1.82
Hospital B.	29,690	53,683	50,000	1.68
Hospital C.	18,734	35,000	12,500	.66
Hospital D.	49,629	66,162	6,875	.13

These figures relate to appropriations for maintenance; inequalities just as glaring appear among the appropriations for buildings, improvements, etc.

In a report made to the Hospital Association of Philadelphia, from which I shall once more take the liberty to quote, Mr. F. J. Firth, who certainly knows the local situation in Pennsylvania as well as any one, explains that "the petitioners appear in considerable numbers and are often subject to long delays before they are reached, and with not much possibility of the board being able to give any one petitioner a full and detailed hearing. Upon no systematic plan, so far as is known, the board decides upon the amount it will recommend that the legislature shall grant to each applicant. The applicants then move upon Harrisburg. They interview and seek to bring friendly influence to bear upon the members of the legislature to induce favorable action upon their petitions. The legislature may, and does, appropriate to other institutions and in other amounts than those recommended by the Board of Public Charities. The unequal and seemingly inequitable distribution of public funds that always results from the practice now governing has caused many good citizens to condemn the entire policy of the state funds to the support of institutions owned and operated by the state."

RHODE ISLAND.

In Rhode Island appropriations are made by the state and by municipalities for the benefit of private charities.

In the City of Providence there is no municipal hospital, and the city recognizes by annual appropriation the charity work done by private institutions. For the past fifteen years the City of Providence has appropriated sums varying from \$3,000 to \$5,000 per annum for the maintenance of

the ambulance service of the Rhode Island Hospital, which ambulance service covers the entire City of Providence. For some years the city has appropriated \$5,000 additional, practically as a gift to the hospital, but legally designating this sum for the support of injured policemen and firemen. During the past three years the City of Providence has also appropriated \$30,000 annually in recognition of the work done by the hospital for the City of Providence. There is no uniform ratio between the amount of the appropriation and the number of days of treatment given.

The Providence Lying-In Hospital receives an appropriation of \$2,500 annually from the state; the appropriation is made by the legislature, and is included in the General Appropriation Bill. This hospital also receives an appropriation of \$5,000 from the City of Providence, this item being included in the annual budget prepared by the Finance Committee.

SOUTH CAROLINA.

Charleston, by a vote of its city council, allows \$28,000 per annum for the partial support of the Roper Hospital; the additional requirements of the hospital are met chiefly by the payments of private patients.

TENNESSEE.

Indigent patients of the City of Knoxville are cared for satisfactorily in the Knoxville General Hospital (103 beds), which is managed by a Board of Governors, half of whom are chosen by the city. The city originally contributed \$40,000 toward the cost of erecting the hospital building, and in 1908 appropriated \$6,480 toward the ambulance fund.

TEXAS.

Houston is under contract with the Sisters of Mercy to pay 60c per day for each patient cared for in St. Joseph's Infirmary, limiting its total expenditures for this purpose, however, to \$2,400 per annum.

Laredo pays \$240 per annum to the Mercy Hospital for the use of four beds.

The Hotel Dieu, at El Paso, is conducted by Sisters of Charity, and is exempt from all state, city and county taxes.

The Sisters permit the use of two beds by the city and two beds by the county, without charge.

VERMONT.

The State of Vermont has enacted the following laws concerning appropriations by towns for the support of non-sectarian hospitals (Chapter 155, Title 19, Regulations and Powers of Towns):

Sec. 3532. *Appropriation for hospitals.* A town may, at any legal meeting of the voters thereof, when an article for such purpose has been duly inserted in the warning for such meeting, appropriate such sums of money as it deems necessary for the support of any non-sectarian hospital established therein which is incorporated by an act of the general assembly.

Sec. 3533. *Appropriations for free hospital beds.* A town, at a meeting duly warned for that purpose, and a city, by vote of the mayor and aldermen thereof, may appropriate such sum of money, not exceeding three hundred dollars, for a free hospital bed for a period of not less than one year, and may appropriate such sum of money, not exceeding five thousand dollars, for the permanent endowment of a free hospital bed, as such town or city deems advisable, for the use of the inhabitants of such town or city as are entitled to receive assistance by reason of their indigent circumstances.

Sec. 3534. *Same; contract with hospital.* The treasurer of a town or city making an appropriation as provided in the preceding section may make a contract with such hospital concerning the admission of patients thereto; and the rate, rules and regulations governing such admission shall be approved by the selectmen of such town or the mayor and aldermen of such city before a payment of money is made to such hospital.

In accordance with the state law, a contract has been made by the Rutland Hospital to keep five free beds at the disposal of the City of Rutland.

VIRGINIA.

The Constitution of Virginia (Section 67) forbids the appropriation of public funds to hospitals not owned or controlled by the state, but the General Assembly is empowered to authorize cities, counties and towns to make such appropriations in their discretion. The right so to appropriate public moneys is specifically granted to a num-

ber of cities and towns in their charters and Norfolk is one city which exercises this right. Section 67 of the State Constitution reads as follows:

"The General Assembly shall not make any appropriation of public funds, of public charity, or of any real estate, to any church or sectarian society, association or institution of any kind whatever, which is entirely or partly, directly or indirectly, controlled by any church or sectarian society; nor shall the General Assembly make any like appropriation to any charitable institution which is not owned or controlled by the State; except that it may, in its discretion, make appropriations to non-sectarian institutions for the reform of youthful criminals; but nothing herein contained shall prohibit the General Assembly from authorizing counties, cities or towns to make such appropriations to any charitable institution or association.

In Norfolk, St. Vincent's Hospital was under contract for a number of years with the city. The contract provided that the hospital should set aside twenty-four beds for the use of city patients, for which an allowance of \$1,200 per year was granted; it was stipulated that twenty of the beds should be under the care of the visiting staff of the hospital. This contract was recently allowed to lapse, and St. Vincent's Hospital now takes city patients at one dollar per day in its general wards, just as it receives any other patients. The Norfolk Protestant Hospital is paid at the same rate for the same service.

In Lynchburg the Board of Aldermen appropriates \$125 per month to maintain four beds for city patients in the Marshall Lodge Home.

The Danville General Hospital cares for all patients referred to it by the city physician, and receives for this service a municipal allowance of \$1,800 per annum.

Petersburg, in consideration of an appropriation of \$100 per month, has the privilege of using four beds in the King's Daughters' Hospital.

Twelve hospitals in the City of Richmond are aided by small annual municipal grants. In 1908 the city devoted \$5,100 to this work; the largest single appropriation was \$500, the smallest \$100. The mayor of Richmond, in a letter to Mr. Walter Mucklow, writes that "the city makes

no special claim on any of these institutions, but contributes to their support on the theory that but for the aid furnished by these hospitals, the City Home (Almshouse) would be burdened with many additional dependents."

Roanoke, which annually contributes \$1,000 to the Roanoke City Hospital, has the right to use two cots in a public ward of the hospital, and is represented by its mayor on the board of management of the hospital.

UTAH.

There are no free hospitals in Salt Lake City. Indigent patients are sometimes sent to private hospitals in Salt Lake City on the order of the public authorities; in such cases the city or county pays the actual cost of maintenance.

WASHINGTON.

In 1908 the city council of Seattle paid \$700 per month for the support of free patients in the Wayside Emergency Hospital. These appropriations were made in recognition of the large amount of work done by the institution named, there being no public hospital in Seattle.

The private hospitals at Bellingham receive 85c per day for each county patient treated by them.

WISCONSIN.

Sheboygan supports two beds in St. Nicholas Hospital at an annual charge of \$600. An additional sum of about \$1,500 per annum is paid by the city for the care of indigent patients requiring additional accommodation.

St. Agnes' Hospital, Fon du Lac, receives no regular city appropriation, but is paid by the municipality for the care of proper cases.

ALBERTA.

The Hospital Ordinance of the Province of Alberta, as amended in March, 1907 (Chapter 5 of the Acts of Alberta) reads in part as follows:

"To each hospital in the province filing with the department the returns called for by this ordinance, there may be paid out of any moneys appropriated in that behalf by the Legislative Assembly the following sums:

(1) Twenty-five cents per day for each day's actual treatment and stay of every paying patient in such hospital;

"(2) Fifty cents per day for each day's actual treatment and stay of every non-paying patient in such hospital:

"Provided, that for the purposes of this ordinance every person admitted to or being within any hospital for treatment shall be taken as a paying patient who pays or for whom there is paid to such hospital from any sources other than the public funds or moneys of the province a weekly sum of not less than five dollars.

"The Lieutenant Governor in Council may prescribe regulations respecting the management, maintenance and accommodation of all hospitals receiving public aid under this ordinance.

"Any hospital receiving aid from the province shall forward to the department by registered mail within thirty days after the 30th day of June and 31st day of December of each year a return showing the number of days' actual treatment and stay of every patient in such hospital for the preceding six months, and the commissioner may from time to time fix and direct the particulars to be contained on and the form, manner and time of making returns; and shall fix and direct the form and manner of oath, affirmation or declaration required for the verification of any such return and the person or persons by whom such oath shall be made.

"The Commissioner may appoint one or more inspectors to inspect and report upon every such hospital; and for such purpose such inspector or inspectors shall make all proper inquiries as to the maintenance, management and affairs thereof and by examination of the registers and by such other means as may be deemed necessary satisfy himself or themselves as to the correctness of any returns made under this ordinance.

"If any inspector should report that any patient was not a fit subject for hospital treatment for all or part of the time during which he has kept in the hospital, the commissioner may refuse to make any payment in respect of such patient for the time during which he is so reported as not being a fit subject for hospital treatment.

"Any person who knowingly and willfully makes or is a party to or procures to be made directly or indirectly any false return under this ordinance shall thereby incur a penalty of \$100, which penalty may be recovered with costs by a civil action or proceeding at the suit of the Attorney General in any form allowed by law in the supreme court of the Territories."

The provincial appropriations for the fiscal year ending June 30th, 1907, the total financial operations of the hospitals aided, and the value (cost) of the charity work done by the hospitals are shown in the following table:

The Appropriation of Public Funds

Name of Hospital.	Cost of Maintenance.	Total Expenditures (including Cost of new Buildings.)	Value of Charity Work Done.	Gov't Grant. July 1-Dec. 31.	Gov't Grant. Jan. 1-June 30.
Calgary General	\$21,597.53	\$30,545.90	\$5,538.26	\$1,944.75	\$2,518.50
Edmonton General	9,069.29	51,382.82	2,142.23	1,724.25	2,777.25
Edmonton Public	11,789.02	23,038.33	3,929.55	1,079.50	1,981.50
Misericordia, Edmonton	7,908.96	17,262.70	941.27	1,500.75	2,787.50
Galt, Lethbridge	13,630.06	17,867.01	3,789.76	1,129.50	1,381.75
Holy Cross, Calgary	17,105.25	73,897.29	4,350.81	2,228.00	2,687.75
Macleod General	4,437.64	9,412.46	1,100.40	347.75	606.75
Medicine Hat General	13,524.99	54,067.74	4,167.68	1,737.50	3,114.25
Pincher Creek Memorial	2,769.90	3,732.92	559.30	166.00	178.00
Red Deer Memorial	3,286.37	7,201.19	721.99	326.75	.....
Roland M. Boswell	2,837.03	3,370.55	823.03	54.50	263.75
Strathcona General	7,526.71	7,955.16	.....	851.00	.....
Isolation, Edmonton	2,262.39	33,269.24	2,206.68	.....	.....
S. A. R. and Mater. Home	2,324.59	3,788.66	745.50	285.00	570.00

There is no general law in Alberta authorizing appropriations by municipalities for the benefit of private hospitals, but in the absence of any prohibition, cities are free to make such appropriations if they wish to do so.

The present arrangement between the hospitals and the provincial government is reported by Dr. L. E. W. Irving, the Provincial Health Officer, to be unsatisfactory to the hospitals, which desire more liberal grants than they now receive. The reasons for this demand are set forth in Dr. Irving's official report for the year 1907, from which the following quotation is taken:

"The present method of allowing twenty-five cents per diem for paying and fifty cents per diem for non-paying patients, does not work out well in practice. Many of the patients entering as paying patients are unable to, or do not, pay after they have received treatment, thus placing the hospital authorities at a loss. It would be better if a definite amount per patient were allowed for every patient entering the hospital, whether he be a paying or non-paying patient.

"Another feature which was brought to my notice was the expense that the different hospitals are put to in providing treatment, care and maintenance for patients that come from outside the municipalities or districts in which the hospitals are situated, the hospital authorities claiming that they are unable to collect any thing to defray these expenses from such municipality or district where the patient resides and, therefore, the hospital caring for such patient at a loss."

MANITOBA.

Under the Charity Aid Act the Manitoba Government contributes to incorporated hospitals a certain sum per day for each patient treated. The grants to the several hospitals are duly reported in the public accounts, published annually, and it is customary to include in the report of the Department of Agriculture a complete financial report of each subsidized hospital. Hospital grants made by Manitoba for the year 1908 were as follows:

Winnipeg General Hospital	\$39,203.24
St. Boniface Hospital	35,523.00
Dauphin Hospital	2,715.00
Morden Hospital	1,346.99
Soeurs de Misericorde	6,662.62

Soeurs de Misericorde, Building Fund....	5,000.00
Shoal Lake Hospital	461.25
Grace Maternity Hospital	7,255.50
Neepawa General Hospital	1,063.87
Teulon Hospital	902.25
Swan River Hospital	650.00
Portage la Prairie Hospital.....	2,319.37
Brandon Hospital	6,041.27
Souris Cottage Hospital	260.62
Carman	1,091.25

All hospitals receiving aid from the government are under inspection of an officer of the government, known as the Inspector of Public Institutions.

In accordance with an amendment to the Charity Aid Act approved in March, 1909, hospitals have the right to claim from the municipality from which a charity or public ward patient registers, a sum not in excess of \$1 per day for each day of free treatment given. If a public ward patient's account be paid in part, the hospital is entitled to recover from the municipality the unpaid balance. Subsequently, the municipality may recover any sum paid in settlement of a patient's account by collection or by suit against the patient, or in the event of his death, by suit against his executors or administrators. The method of procedure followed in such cases is fully described in the following extracts from the law:

"14. In this Act, unless the context requires a different construction, the word "hospital" shall mean and include all public hospitals incorporated by a special Act or by letters patent under the great seal of the Province of Manitoba and receiving aid under this Act, and in cities of ten thousand and over shall mean a hospital with at least fifty beds and a building that shall be declared suitable for hospital purposes by the inspector of public buildings for the Province, and, in places with less than ten thousand, at least fifteen beds and a suitable building subject to the said inspection, and the word "resident," as applied to a municipality, shall mean and include any person who has resided in such municipality continuously for one month, or who, though not having resided therein continuously for such month, was actually employed therein immediately prior to being admitted to any hospital.

"15. The proper officer of such hospital, immediately upon the admission of any patient to any public ward in such hospital, shall notify by mail the clerk of the municipality from which such patient

represents himself or is represented as being brought, that such patient has been admitted to such hospital, giving any other necessary particulars to enable the clerk of the said municipality, city, town or village to identify the patient, and, unless the said clerk, within fourteen days after the mailing of said notice, shall notify said hospital in writing that said patient is not a resident of the said municipality, he shall be so considered for the purposes of the Act. And upon the discharge or death of such patient the said officer shall immediately notify the clerk of the said municipality and the Municipal Commissioner, enclosing to each a detailed statement of the account of such patient with the hospital (if unpaid by such patient or any one in his behalf), or so much thereof as shall be unpaid, and, upon the said municipality being notified as hereinbefore provided, the said municipality shall become liable to said hospital for the amount of the claim of the said hospital against such patient if, at the time of his admission to the said hospital, he was a resident of such municipality, and every such claim shall become a debt due from the municipality to the hospital.

"17. No hospital shall charge any municipality for nursing and attendance upon any public ward patient a higher rate than \$1 a day, except as hereinafter provided.

"18. In the event of the death of any public ward patient in any hospital, the municipality of which such person was a resident immediately prior to being admitted to such hospital shall be liable to the hospital for the burial expenses of such patient, not exceeding the sum of \$15, and said amount shall become due in the same manner and the liability of the municipality for payment thereof shall be subject to appeal to the Municipal Commissioner in the same manner as an account of such hospital for treatment.

"20. Upon payment by any municipality of any account of a hospital for treatment or burial of any public ward patient, as hereinbefore mention, the said patient or his executors or administrators shall immediately become liable for and shall pay to such municipality all sum or sums so paid, and in addition to the remedy hereinafter provided the said debt may be collected and sued for by such municipality in the same manner as an ordinary action for debt, and neither the patient nor his estate shall be allowed to claim any exemption under any statute of the Province of Manitoba as against any such claim by such municipality as aforesaid.

"22. It shall be lawful for any municipality and any hospital, by agreement between themselves, to provide that the municipality may pay a fixed annual amount to such hospital in lieu of any liability under the provisions of sections 12, 16, 17 and 18 of this Act to any such hospital, and any such agreement shall operate to

relieve the municipality entering into the same from any liability under the provisions of the said sections to any such hospital."

NEW BRUNSWICK.

The sum of \$9,700 was appropriated by the Legislative Assembly of New Brunswick in 1908 in aid of the following hospitals:

St. John General Hospital, St. John County.....	\$3,800.00
St. John Maternity Hospital, St. John County.....	300.00
St. John Maternity Hospital, St. John County.....	250.00
St. John Silver Falls Hospital, St. John County.....	600.00
Campbellton Hospital, Restigouche County	600.00
St. Basil Hospital, Madawaska County	600.00
Chatham Hospital, Northumberland County	700.00
Tracadie Hospital, Gloucester County	600.00
Fredericton Hospital, York County	700.00
Woodstock Hospital, Carleton County	600.00
St. Stephen Hospital, Charlotte County	600.00
Moncton Hospital, Westmorland County	700.00
	<hr/>
	\$9,700.00

The report of one of these hospitals, the Moncton Hospital, shows that a provincial grant may be, and in this instance is, supplemented by relatively liberal appropriations by city and county; and that the principal sources of hospital income, other than public appropriations made by province, city and county, are (a) receipts from paying patients, and (b) private donations:

Receipts of the Moncton Hospital, from June 1st, 1906, to May 31st, 1907.

Paying patients	\$4,266.08
City grants	1,200.00
Westmoreland County grant	1,000.00
Local Government grant	700.00
Kent County grant	200.00
Special City grant for Nurses' Home	500.00
Received of Ladies' Aid for Nurses' Home.....	2,000.00
Subscriptions and cash donations	952.67
Overdraft at bank and outstanding checks	775.54
	<hr/>
	\$11,594.29

NOVA SCOTIA.

The statutes of the Province of Nova Scotia authorize payments to hospitals by municipal and town councils, and provide appropriations on a per capita basis from the Provincial Treasury. The government Inspector of Humane and Penal Institutions, Dr. George L. Sinclair, states that the sums following were allotted by the government to the several hospitals named in 1908:

	Amount of Grant.	Hospital Days.
The Aberdeen Hospital, New Glasgow.....	\$ 963.60	7,693 days
Highland View Cottage Hospital, Amherst..	961.80	6,116 days
St. Martha's Hospital, Antigonish.....	371.40	1,859 days
Brookland Hospital, Sydney	1,732.20	6,161 days
Pictou Cottage Hospital, Pictou.....	536.70	1,613 days
St. Joseph's Hospital, Glace Bay.....	5,201.00	23,500 days

The provincial statutes referring to the subject are as follows:

"(1) Municipal and town councils are hereby authorized and empowered to grant aid to any public hospital for the treatment of the sick, established or to be established in the Province of Nova Scotia, in such amounts as they from time to time determine, and to vote rates, and collect the same from the ratepayers in the same manner as the rates and taxes for the ordinary authorized services of the municipality or town are rated and collected.

"(2) The Governor-in-Council is authorized to pay out of the Provincial Treasury in aid of any such hospital to the recognized governing board thereof a sum to be computed according to the following scale, that is to say:

"(a) At the rate of thirty cents for each day's actual treatment and stay of a patient in such hospital during the fiscal year of the Province next preceding the year for which such aid is given, until the amount of such aid reaches one thousand five hundred dollars;

"(b) After such aid amounts to the sum of one thousand five hundred dollars, at the rate of twenty-five cents for every additional day's actual treatment and stay of a patient in such hospital during the said fiscal year.

"(3) No hospital shall receive any allowance under the provisions of the next preceding section until the same is formally recognized by the Governor-in-Council as entitled to the benefits of this Chapter.

"(4) The aid authorized by this Chapter may be given to hospitals of the character mentioned in this section and to none others, that is to say:

"(a) Any hospital established or maintained by a municipal council or town council.

(b) Any hospital established and maintained by private persons or benevolent organizations, where such hospital is recognized by resolution of the council of the town or of the municipality within which it is situated as a public hospital, and where such council has granted to it not less than three hundred dollars per annum, and where the governing body of the hospital includes a representative appointed by such council.

"(5) One member of the governing body of every hospital receiving aid from the province under this Chapter shall be appointed by the Governor-in-Council, and shall hold office during pleasure.

"(6) Every hospital receiving aid from the province under the provisions of this Chapter shall be subject at all times to the inspection of any officer authorized to make such inspection by the Governor-in-Council, and the aid authorized by this Chapter may be withheld if the reports of such inspector are not deemed satisfactory.

"(7) The by-laws and regulations of every hospital established under this Chapter shall be subject to the approval of the Governor-in-Council.

"(8) All claims made upon the provincial treasury for the aid authorized by this Chapter shall be verified by the affidavit of one of the provincial officers of the hospital, in such form as is required by the Provincial Secretary.

"(9) This Chapter shall not apply to any hospital in the City of Halifax."

Very sweeping and unusual powers are vested in the official to whom, under the preceding law, is assigned the duty of inspecting and reporting on the work of hospitals which receive permanent aid. It is doubtful if any private hospital would agree to accept a governmental subsidy if it were actually compelled to submit to the dictatorship of an inspector having the right to make rules and regulations concerning the "medical attendance" of its staff, and religious instruction, and the "whole interior economy and management of the institution." Such is the power conferred by law on the Inspector of Humane and Penal Institutions of Nova Scotia; but the official reports of the

department indicate that, far from exercising his power in a tyrannical way, the inspector, in his dealings with semi-public hospitals, contents himself with the presentation of such reasonable recommendations as are justified by the obvious needs of the institutions and their patients.

The powers and duties of the Inspector of Humane and Penal Institutions are fully set forth in Chapter 49 of the Provincial Statutes, as follows:

Chapter 49 of the Inspector of Humane and Penal Institutions.

"1. The Governor-in-Council shall appoint a fit and duly qualified medical practitioner to be inspector of the Nova Scotia Hospital, the Victoria General Hospital, and all local hospitals, etc., receiving aid from the government of Nova Scotia, to be known as the Inspector of Humane and Penal Institutions.

"2. (1) The Inspector shall have power from time to time, subject to the approval of the Governor-in-Council, to alter, amend, or rescind any existing rules or regulations for the government of local hospitals, poor houses, asylums for the harmless insane, sanitariums, common jails, reformatories, and all other humane or charitable institutions receiving aid from the government of Nova Scotia in this province, and to frame and adopt other rules and regulations in that behalf relating to—

"(a) the maintenance of patients or prisoners, in regard to diet, clothing, bedding and other necessities.

(b) the employment of such patients or prisoners,

(c) medical attendance,

(d) religious instruction,

(e) the conduct of patients and prisoners, and the restraint and punishment to which they may be subjected,

(f) the treatment and custody of patients generally, and the whole interior economy and management of such institutions, and all such matters connected therewith as are considered by him expedient; and such rules and regulations shall be submitted to the Governor-in-Council for approval and confirmation.

"Nothing in this section contained shall prevent the municipal councils from making such special regulations as the peculiar circumstances of the respective institutions in their localities require; such special regulations, however, shall not be inconsistent with this Chapter, or with the general rules and regulations so made by the inspector, and approved by the Governor-in-Council.

"(3) The inspector shall, at least twice in every year, visit and inspect all such institutions as are in the next preceding section mentioned, and any other institution named by the Governor-in-Council.

"(4) At such inspections he shall satisfy himself that the management, organization, equipment and staff of employees are in accordance with the requirements of the institution, having in view the purpose for which it is intended, and shall also note the number and character of the inmates, and the admissions, discharges and deaths since his last inspection.

"(5) He shall annually make a report in writing to the Governor-in-Council in respect to every institution visited by him, its management, general condition as to efficiency; number of inmates, and the state of the building in regard to the health and comfort of the inmates, together with such suggestions for improvements as he deems necessary and expedient.

"(6) The inspector, if he thinks fit, may examine any person holding office or receiving any salary or emolument in any such institution, and may call for and inspect any books or papers of or relating to any such institution, and inquire into any matters concerning the conduct and management of any such institution.

"(7) When the inspector considers it expedient, or is directed by the Governor-in-Council, to inquire into the management of any institution required to be inspected by him under the provisions of this Chapter, or into the truth of any return made by the officers of such institution, the inspector may hold such inquiry, and for the purposes of such inquiry shall have the same power as to summoning such officers or other persons to attend as witnesses, and to enforce their attendance, and to compel them to produce documents and give evidence, as are conferred upon a commissioner under the Chapter of the Revised Statutes, entitled "Of Inquiries Concerning Public Matters."

ONTARIO.

A provincial grant is made in Ontario for all patients in hospitals which are in the first ten years of their existence, at the rate of twenty cents per day, irrespective of what sum is contributed by the patients themselves. After a hospital has been in existence for ten years the grant is paid only for patients for whose maintenance \$4.90 per week or less is otherwise contributed. In all cases the limit is 120 days, and if a patient remain in the hospital longer than that period the "refuge rate" of seven cents per day is allowed. Children over one year and under twelve years are allowed for at the rate of seven cents per day. No allowance is made for infants under one year of age.

The total provincial grant to private hospitals in Ontario for the fiscal year ending October 1st, 1908, was \$146,268, and the total income of the hospitals benefited by provincial grant was \$1,278,000. The average cost of maintenance of patients was \$1.21 per day for 1,034,591 days of treatment, the provincial grant representing .1388 of the total expenditure for maintenance.

The municipalities of Ontario, under the terms of the Municipal Act, are permitted to make annual grants for the support of local hospitals. In a report on the prisons and hospitals of Ontario, published early in the present year, the Inspector of Prisons and Public Charities not only appeals to the municipalities of the province to exercise more liberally than they have yet done the privilege of co-operating with local philanthropists in establishing and maintaining local hospitals under private management, but he urges an amendment to the Charities Aid Act (such as the recently enacted law of Manitoba) which would give to the trustees or managers of private hospitals the power to collect from municipalities the actual cost of maintenance of patients who are unable to support themselves during illness. The views of the inspector, Dr. Bruce Smith, are sufficiently interesting and authoritative to warrant extended quotation. He writes as follows:

"The contrast between municipal hospitals and those institutions which are controlled and directed by local boards is most marked. There are only two or three what might be termed municipal hospitals in Ontario. Where these are located there is an absence of the hospital spirit among the people of the community. Local philanthropy is never exerted for the benefit of the hospital. It would, indeed, be a surprise for such a hospital to receive a contribution or become the object of a bequest. Not only is the hospital deprived of the contributions and sympathy of the people of the community, but the greater privilege of giving is kept from those who would otherwise find comfort and delight in practical benevolence.

"There is no room in Ontario for more hospitals solely under municipal control. The ideal plan is, as so largely prevails in this Province, local management under the direction of those who are actuated by a spirit of philanthropy coupled with civic pride, and are willing to administer the important trust committed to their care. These local boards, however, deserve and must receive mu-

nicipal support. The municipal act of Ontario gives power to vote an annual grant each year for hospital support. Every city, town, village, township and county council can exercise that power. Some of the municipalities make liberal grants towards the support of the hospitals in their midst. Unfortunately, there are many that will not take advantage of the power they possess to vote hospital grants. Some municipalities decline to contribute anything towards paying for the hospital care and treatment their indigent patients receive. The time has come when municipalities should be awakened to a sense of the duty they owe to the local hospitals who care for their sick poor."

QUEBEC.

By special laws and special votes of the provincial parliament, voluntary hospitals in Quebec are frequently granted appropriations from the public funds both for current maintenance and for building improvements. In some cases the municipalities of the province are empowered to assist local hospitals. Subsidized voluntary hospitals are subject to government inspection and regulation.

In conclusion, I wish to express my sincere thanks to the public officials, members of this association, and others who have kindly aided in the collection of the foregoing data. I am especially indebted to Walter Mucklow, Esq., Secretary of the Board of Trustees of St. Luke's Hospital, Jacksonville, Fla., who very generously placed at my disposal some two hundred letters received by him in 1908 in response to a circular letter of inquiry on the subject of municipal hospital appropriations. Through Mr. Mucklow's kindness, I have been enabled to add very materially to the volume of statistical information embodied in this report.

RANDOM SUGGESTIONS REGARDING HOSPITAL CONSTRUCTION AND MANAGEMENT.*

DR. R. W. CORWIN,

Superintendent, Minnequa Hospital, Pueblo, Colo.

Remember, in building a hospital, that it is for the sick.

Often, too much attention is given to the administration department, and not enough to the hospital proper.

One not infrequently finds in a hospital a beautiful foyer and an elegantly carpeted and curtained board room; ornamented halls and offices, but less desirable apartments for patients.

In building a hospital, remember the poor as well as the well-to-do.

All rooms should face outward. Inside and back rooms are objectionable.

If all rooms be well located there will be no excuse to give the poor the less cheerful, and the well-to-do the more desirable quarters.

The architect sometimes seems to have given his best efforts towards pleasing boards and doctors, and to an extent at least, overlooked his real mission, namely, building a hospital which is for the accommodation of the sick, and not for the special accommodation of the well.

SELECTION OF GROUND.

Let the selection of ground be made:

- a. Where there is plenty of room.
- b. Where there is plenty of good air.
- c. Where there are pleasant surroundings.

*Read by Dr. J. N. E. Brown.

- d. Where the patients may have plenty of opportunity to get out of doors.
- e. Where the patients may get next to nature—among the trees and upon the grass.
- f. Where they may get away from noises, dust and dirt.
- g. The country is the best place for a hospital; patients get well quicker in the country than in the city.

It is cheaper to transport patients from a city to the country and bring them back to their homes than it is to keep them in the city where the cure is apt to be delayed. Relatives may object at first, but when they learn that it is to the advantage of the patient, they will demand that the patient have these advantages.

Doctors may object and desire that a hospital they attend should be placed where it is convenient for them to attend cases. The doctor should be considered, but not first—the hospital should always be located where the patient will do best.

The buildings should be fireproof—this is imperative.

The buildings should not be high.

- a. Two stories are quite enough.
- b. Spread the buildings upon the ground instead of putting them up in the air.

It is no excuse to say there is not room. If there is not room for the building, there is not room for air. Go where there are both room and air.

- c. They should be substantial but inexpensive—
No gaudy extravagances outside or inside.
No unnecessary ornamentation.
No faddish notions.
- d. They should be attractive, however, with the idea of sanitation, cleanliness and cheerful homeliness.
- e. Get as far away from the institutional idea as brain and architect can devise.
Nobody likes the idea of going to a hospital.
Nobody likes the looks of a hospital.
Make the building look like anything but a hospital.

THE LOCATION OF BUILDINGS.

Too much care cannot be given to locating the different buildings.

The administrative building.
The hospital proper.
The operating room.
Laundry.
Ambulance barn.
Contagious wards and crematory.
Recreation hall.
Convalescent departments.
Nurses' home.

All should be located with the idea of comfort and convenience of the sick.

Be ever mindful of noises, dust and smells—they not only annoy, but are injurious to patients.

THE KITCHEN AND DINING ROOMS.

These cannot be too carefully located—

The odors from kitchen are distressing to the sick.

The noises from rattling of dishes, pans, pots and kettles harrassing to patients and retard their progress.

They should be located out of reach of patient's nose and ear.

INSIDE OF BUILDING.

- a. The entrance should be light, cheerful and fairly spacious.
- b. It should not have draperies nor unnecessary dust-catching furniture and hangings.
- c. Let cleanliness be conspicuous.
- d. Let everything be inviting.

There should be no stairs nor elevators.

Let the incline take the place of stairs and elevators.

The advantages of the incline are obvious to the thoughtful.

The following extracts, regarding the incline, are taken from our Annual Report (Minnequa Hospital Report):

"Inclines should take the place of stairs difficult to climb,

and elevators expensive to maintain and dangerous in case of fire. The photograph of a child on the stairs, accompanying this report, well illustrates that stairs should be considered a thing of the past in public institutions and in the home. Thoughtlessly, the three-foot child has been made to climb stairs built for a six-foot man. The weak and the stout are made to climb stairs intended for the strong and well. The incline overcomes all these difficulties. The short, the tall, the weak, the strong, and the lame may each take the step best suited to his convenience. A wheel chair or a bed on rollers may be taken up or down an incline with ease. The man on crutches need have no fear of tripping. A crowd may be sent down an incline without danger of a blockade. The incline has every advantage.

"The Chicago Association of Commerce boomers reached Denver today and toured the city in automobiles this evening. Later they attended a banquet. Chicago hospital managers and members of the Outdoor Art League probably will receive tips from the trade extensionists on up-to-date methods as the result of visits of the delegation to Pueblo and Denver today. At the former city the Chicagoans saw what they declared to be the finest hospital they ever had seen. It is an institution provided by the Colorado Fuel and Iron Company. There is not a stairway in the place, inclines being used for the comfort of patients. Tub baths also are barred, being declared unclean. Shower and slab baths take their place. The hospital is built in the center of a spacious lawn, sloping all around and surrounded by scores of trees and flower beds."—(From the Chicago Daily Tribune, June 16, 1909.)

FLOORS.

Flooring is a serious matter.

No floor has yet been devised that is perfect.

On account of expansion, contraction and absorption, perfection cannot be hoped for in any material that has been suggested.

Mosaic, marble, glass, slate, brick and tile are all objectionable on account of noise and cracking, of being slippery

and hard upon the feet. After trying all these substances, as well as various constructions of wood, monolith, petropulp, etc., I have finally resorted to cork carpet.

CORK CARPET IS NOT IDEAL.

It stains some.

It absorbs some.

It is not especially easy to clean.

But it has its good qualities, and, in some ways, has advantages over all other flooring mentioned.

It is noiseless.

It is not cold to the touch.

It is pleasant to the feet of patient and nurse.

It is inexpensive.

It is durable, will last for ten to twelve years when properly laid.

It can be readily coved at the sides if properly protected so that corners and angles may be avoided.

It must be laid on a smooth surface.

It should join the wall with a flush surface.

If the joint shows or opens, cover it with canvas, glue the canvas to the cork and wall, and paint over all.

Thus treated, it will stand water and scrubbing.

The doors should be plain.

They may be made of wood, without panels, covered with canvas, and hermetically sealed by painting. Under this condition they will not crack or warp, and can be readily cleaned.

They should have a top and bottom hinge so that they will swing through and not slam, bang, clatter and click, whenever the wind blows or the nurse passes. In other words, this kind of door is noiseless, sanitary and durable.

If pictures are to be hung in the patients' rooms, let them be hung from low hooks or picture nails, and not suspended by wire from a picture moulding.

Moulding is dust-catcher, out of easy reach, and not easily cleaned.

The windows should be made so they can be opened wide and noiselessly, and arranged for screens. This may not be simple, but it is something for the architect to accomplish.

The window curtains should be hung in such a way that they may be readily removed.

Let them be of an inexpensive washable material, suspended from rods by rings small enough to pass through the mangle without being torn off, or without injuring the curtain.

A four-piece curtain is suggested, that may be opened and closed to any extent desired. If the upper sash be lowered, the upper curtains may be taken down readily, by which continual rattling of the curtains may be avoided when the wind blows.

This sort of curtain has advantages over many other curtains:

It can be kept clean.

It can be made of any material.

It can be as decorative or as plain as desired.

The upper pair can be removed when the upper sash is open and the wind is blowing, and thus avoid the rattling that is often most distressing to a person sitting, or sleeping, in a room.

The fixtures for holding the curtain are very simple—can be home-made.

(See "Simple wooden holders for curtain rods," in accompanying booklet, page 32).

The beds should be narrow, high and long.

Most hospital beds are too short for a full-grown man.

The furniture for the rooms should be made of material that will not give off sounds when brought in contact with other things.

There is no such furniture in the market at present, but it is no excuse to say "It is not in the market." The thing to do is to make suggestions to the manufacturers and they will put something in the market that will meet the needs. Where there is a demand, there will be a supply.

If doctors and nurses appreciate this, it will not be long before manufacturers will make the desired material.

CLOSETS AND LAVATORIES.

- a. Place them with reference to sanitation.
- b. Where no odors or sounds will reach the patients.
- c. Where they may be convenient for the nurse.

BATH ROOMS.

Use shower and slab baths—avoid tubs.

Lead floors I have found more serviceable than any other for bath rooms.

Fixtures painted with aluminum paint are suggested.

Brass is beautiful, but expensive to install and to maintain.

Nickel is not sufficiently durable.

All plumbing should be well away from the wall, so it may be readily cleaned.

One of the most unsanitary things we have in a hospital is a bath tub where people get in, wash their feet first and their faces last, using over and over the same water.

A bath tub may be tolerated in a private house where you know the people who use it are not diseased, but it should be against the law to permit a bath tub in a public institution.

In a hospital everybody is sick, or supposed to be, consequently no one cares to bathe after another—no matter how much pains may be taken to cleanse the tub.

All linen closets and other closets should be made with open shelves which may be approached from all sides.

It is economic in space and more sanitary than closets with doors and drawers.

It gives insects, germs and dust no opportunity of being concealed.

The open shelves bring everything in plain view and demand strict cleanliness.

It is suggested that there be no *kitchens* on the *wards*.

The bringing in of fresh material to be cooked causes labor and noise.

The taking of the refuse causes noise and labor.

I repeat—odors from cooking, and noises from handling and washing dishes and pans, are distressing to the sick.

All this should be done where it cannot be annoying to the patient.

It is not as expensive to prepare the food in a central diet kitchen and deliver it ready to serve as it is to prepare it on many floors, for a kitchen on every floor means you must have as many cooks as you have floors for the sick.

If you have six floors it means six cooks—better is it to have one cook six times as good.

I am boring you, for this paper is already too long.

It would take a volume to give full details for constructing and managing a hospital.

These are simply suggestions obtained from living in a hospital more than thirty years.

It is unnecessary to say a hospital should not contain wards with a large number of beds—such wards belong to the dark ages.

It is well to have rooms large enough for two or four beds, so patients, when convalescing, and do not care to read, may be placed together for company's sake.

The nearer a hospital can be gotten to the idea of a cottage or a home-like institution the pleasanter it is for the patient, and the more prompt the recovery.

To manage a hospital successfully, there can be but one head,—true, that head must have had experience—but never can a hospital be managed satisfactorily with a political board, a board of lady managers, and a board of doctors, etc.

The hospital should be free from odors and hospital smells—

Odors from cooking food.

Odors from wounds.

Odors from medicines should not be permitted.

There is little, or no, excuse for using drugs that give off odors.

NOISES.

They should be eliminated as far as possible, and it is possible to eliminate them almost entirely.

Squeaky shoes, loud talking, clattering of doors and furniture, dropping of brooms, brushes and bottles—all can be avoided if the proper appreciation is felt on the part of those in authority, and sufficient care is given, to control the situation.

The architect who builds a hospital must think of something new to improve conditions. It is not sufficient for him to say, "This is what has been done." This is no excuse and should not be tolerated.

The nurse who makes a noise should be corrected, and, if she does not correct her ways, she is not fit to continue at nursing. It is no excuse for her to say, "I could not help it," or, "I did not mean to do it."

The doctor who says he doesn't mind the smell of iodoform, creosote or lysol, has missed his vocation. It is not for him to decide, but for the patient to determine whether the odors are offensive.

The time is passed when a patient should be treated in cheap wards or rooms because he is poor.

Most hospitals are constructed for the benefit of the public, and most of us are not wealthy nor able to pay for luxuries, consequently our thoughts and devotion should be for those who are helpless financially and physically. The poorest man should be given the best treatment—he deserves the greatest attention because he is helpless. The rich can take care of themselves—they can pay for more than necessities.

In constructing a hospital, build it for the rich, and it will be just right for the poor.

Give as much attention to diet as to medicine or surgery—this is often sadly overlooked.

CONCLUSION.

Build your hospital with the sole idea of accommodating patients.

Build it where they will recover quickest.

An architect who does not study and understand the needs of the sick is not the architect one should employ when building a hospital.

Avoid objectionable features.

Permit no hospital odors—odors from cooking, from wounds or from medicine.

Keep the house quiet—allow no loud talking, nor walking, from doctors, nurses, visitors, or patients.

Do not permit the furnishings of the rooms by the party.

Invite friends to give money, but let the management supervise the furnishings.

A doctor who says he does not mind the smell of iodoform ought to change his profession. It is not the doctor's comfort that is to be considered, but the patient's welfare.

A nurse who talks, walks or laughs, to the disturbance of the patients, is thoughtless: a thoughtless nurse is worthless—let her go.

The dietitian who does not learn the likes and dislikes of her patients as well as to know food values, has much to study and learn.

The visitor who calls on the sick and remains long should be sick for a time so as to appreciate what bores visitors are.

Friends who send cut flowers to the sick lack in thoughtfulness. Cut flowers are associated with the dead—they are placed about the casket and strewn upon the grave, and this is quite appropriate, for they, too, are dead. To the dead send the dead, but to the living send the living plant.

A superintendent of a hospital who cannot comprehend the peculiarities, whims and idiosyncrasies of the sick, who fails to overcome objectionable features, and does not love his work better than himself, will be a failure, and the sooner he changes his vocation, the better.

THE RELATIONSHIP BETWEEN THE ARCHITECT AND DOCTOR IN PLANNING
A HOSPITAL:

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It certainly is far from the intention of the present speaker to speculate on any ideal relationships which might exist between the "medical" and "architectural" professions in the construction of a hospital. You with your much wider experience are far better qualified than am I to do that. I wish to speak of the various relationships which I have observed to exist and to draw from these few observations some simple conclusions which may possibly be of value to some one yet to plan a hospital.

Of course we must grant at the outset that the relationship in the case of a given hospital is and must be almost predetermined by the conditions under which that hospital is to be erected. If a doctor builds a hospital for his own private use and provides the funds for its erection, it is quite certain that he will have his own way with the plans. If a university with single services of medicine, surgery, pediatrics, etc., builds a new medical, surgical or pediatric clinic, the head of the department interested will doubtless be allowed to express his opinion as to the construction of this building. But if a city, a church, a board of trustees or a private individual proposes to build a hospital and appointment to its services is to be an honor to be conferred upon one, several, but generally too many, fortunate doctors, then the latter will surely not be consulted in its plans and will, if they are wise, not volunteer any advice. In the last case an architect will be appointed

who will consult his various medical friends who may or may not have had experience in hospital construction but who will volunteer lots of advice: the building committee, if there be one, will visit certain prominent hospitals and get rudimentary education in hospital construction; and the building which finished will probably be a peculiar combination of ideas and not very satisfactory to any of the very ones who will use it. Such are the conditions in America. Here there is no place where the architects, the building committees and the physicians may have access to a sufficient literature on this subject and to a collection of the plans of various hospitals, especially those recently erected.

The criticism is made that our American doctors do not know enough of hospital construction to have an opinion worth asking. But why should they? Did a doctor have use for such knowledge, he could inform himself on those points concerning which his medical training makes his advice of value. The criticism is made that the doctor has not the practical experience of the business man in the general problems of building, heating, ventilating and lighting. No, he has not and need not have. That is the architect's, the builder's and the trustee's business. It is the medical idea to be embodied in the building (the ward unit of number, the general floor plan) which the doctor should decide, and then the business man can make these ideas practical. As it is now the business man must gain these medical points from a doctor or medical authority. But from whom?

But, say others, the hospital superintendent should decide all questions of plans, etc., and this is my opinion exactly—if the hospital superintendent is a doctor. He has the best chance to learn the various methods of construction and in America he is the "fixed point" in the American hospital administration. But how will he get his information? Each surgeon does not devise a new operation for, nor does each physician outline a new treatment for each disease. There are certain well-known operations for each condition and each surgeon is expected to know all and to be able to use the one best adapted to the case before him. But how many superintendents know of the

way problems in medical treatment have been met by others in the construction of the hospital building? Where can he learn? What collection of plans is there which he can visit? And where does the architect get his information concerning the medical needs of the institution? The fact is that in this country we follow a general and uniform scheme of ward arrangement which is at least fifty years behind the times and is not at all suited to the needs of the twentieth century medical knowledge.

A few years ago I visited the new hospitals of Europe to pick up new points in plans, and the following remarks are drawn from the observations made on this trip:

The study of the hospitals of Great Britain were to me exceedingly interesting, since not one seemed to embody any particular medical idea. The medical boards, composed for the most part of business men, seem to have had the plans under their exclusive control. The women superintendents of nurses, who often serve also as the hospital superintendents, were given considerable liberty in making suggestions. The result is that the English and Scotch hospitals have the most perfect ward furniture, I believe, of any hospitals in the world. The details in the wards are almost perfect. The height and size of the glass panels in the swinging doors, the height of the window sills, the size of the wheels of the beds, the size of the iron rods of which the bed frames are made, the shape and the number of the hooks in the lockers, the details of the railings of the balconies, the models of the chairs used, the color schemes followed in the walls and floor tilings, all have been carefully studied out and one cannot help wondering at the number of trifles which go to make this perfection. Cleanliness is the watchword in the hospitals of Great Britain. In several hospitals the rooms are so constructed that in five minutes every piece of furniture can be moved to the center of the room, leaving floors and walls bare, without a projecting edge, a hook or a hole, not a crack where an ant or a water-bug could hide. The kitchens and especially the bath rooms and toilet rooms are wonderfully perfect.

And yet one finds here strange inconsistencies: expensively tiled walls and wooden floors; tiled window frames with the edges all of rounded tiles, and wooden window sashes and wooden doors; Mother Goose pictures baked in tiles at an expense of \$200 each, and these set into the walls so that there is not a projecting border (this was the acme of expensive sanitary precaution), and yet in this room a mattress on the floor for all the children to play on; a careful avoidance of set bowls with running water in the wards, and yet one common crockery bowl and water pitcher to be used each time the doctor or surgeon wishes to wash his hands.

But whereas the ward equipment is on the whole so perfect the hospital buildings themselves are not. The influence of the architect, untrained for medical work, is strikingly seen in the difference between the inside and the outside of the buildings. For instance, the new Children's Hospital of Edinburgh is built according to the plan of the medieval fortified castle. It has plain walls, the narrow windows, a roof with battlements and even with port-holes for the archers. The building is very imposing and yet there is scarcely one balcony onto which a bed can be wheeled. A balcony, I was told, would not be in keeping with this style of architecture. Another illustration, is the Belgrade Hospital in London, the outside of which looks for all the world like the city residence of a rich Londoner. Looked at from the street one would not suspect that the interior was intended for sick patients, and entering it he is not surprised at the serious limitations which the outside imposes on the arrangement of the rooms. In Great Britain it would seem as if the architects planned the outside of the building first and then used the interior as best they could.

The only distinct contributions to hospital construction would seem to be: the tower for the toilet rooms; that is, a tower separated from the ward by a short corridor with through-and-through ventilation in order that no odors from the rooms in the tower can possibly reach the interior of the ward, an idea which has not been accepted generally as valuable; the entire separation of bath and toilet rooms,

well seen in the St. Thomas, London; a plan not often followed; and finally, simplicity in the children's wards, an idea which is generally accepted. In Manchester, however, they have set an example, which is now being followed in other cities of building the hospital in the open country and several out-patient departments in the most thickly settled quarters of the city. Transportation is now so quick and easy that the patients are easily moved to the hospital, where they can enjoy the fresh air and during convalescence the outdoor life, while the dispensaries, several in number, are where they are most easy of access to the sick poor. Of course it is more difficult for the friends to visit the patients in a suburban hospital than if the hospitals were in the center of the city, and this arrangement is not convenient for the visiting doctors and the medical students whose influence will probably in the majority of cases locate the hospital at a point convenient to them, as just now in Toronto. I know the force of this argument, for while I was a medical student in Paris I had to allow two hours every day for transportation between the various clinics I was following.

And yet there must be some bad flaw in the English hospitals if we may judge them by their bad record of epidemics of the infectious diseases, especially of measles and scarlet fever, for their records contrast very unfavorably with those of the hospitals of Germany and France. At first I thought the difference must be only superficial and due to my insufficient information, but I was later convinced that the difference is actual.

In France the hospitals, with the exception of the Boucicault, are under the control of L'Assistance Publique, a bureau closely related to the police department. Evidently architects trained for hospital construction are employed by the government. Here there are as yet very few new hospitals, but these and the new buildings added to the old are well worth studying, for the effort is successfully made to adapt architecture to the special object of the building. As one might expect, the brilliant and ingenious French mind has made some very interesting contributions to hospital construction. One of these is a system of mechanical

isolation of the cases with contagious diseases, the so-called "Box System," best studied at the new Pasteur Hospital, and at Les Enfants Malades. The Boucicault Hospital is evidently a novice's production, and structurally is a failure. The hospital is the most modern in Paris, and yet is a good illustration that a building should not only fit its object but also the customs of the people. Here there are large wards with the words "18 beds" marked on the walls in large letters, but actually containing 42 beds. Here there are arched ceilings "killing" a great deal of air space, and arched walls down which the moisture trickles. Here are a few private rooms on a small second floor where the patients are woefully neglected. In this hospital is the hygienic appointment of an English hospital, yet with over half of the set bowls broken and with bath-tubs which one would believe had never contained a patient. In fact, throughout most of the Paris hospitals the hygiene is of the simplest character, and even that is not well practiced. Their primitive ideas are well illustrated in a new hospital for children in which the kitchen and the water closets are separated by a partition which does reach the ceiling.

Germany is the country where hospital construction can be studied to the best advantage. German hospital buildings average the best of all countries in plan and in construction. This government employs architects who are specialists in this line of work. Two of the large general hospitals not closely connected with any university are the noted models of general hospital construction in Europe. I refer to the Nuremburg Hospital and the new Virchow Clinic in Berlin. But the various clinics of the university hospitals are more interesting since the professors themselves are allowed to express in brick and stone their idea of what a building for their particular specialty should be. Of course these buildings are inclined to show some extreme ideas, for the architects cannot always modify the impractical ideas of the professor, but each clinic's building does seem to show a definite step forward, for each professor seems to have studied the attempts of others before planning his own building.

In Austria a different method is followed. This government has architects, specialists in hospital construction, who plan the buildings, while the physicians have practically no voice. It was my good fortune to become acquainted with the head of the Hospital Construction Bureau in the city of Vienna. In his office I had access to the plans of every Viennese hospital. Not only that, but could obtain accurate information concerning the important hospitals of Europe and much information concerning each which would never be found in print. The reason given for this system is that doctors are not necessarily specialists in construction, but their ideas are apt to be extreme, impractical and changeable. But this system also has its dangers. The new St. Joseph Hospital is perhaps the highest type of this method of hospital construction, and yet the plans of these buildings are more complex than a doctor or nurse would suggest. Also an architect is in danger of carrying to extremes some medical fad which appeals to him. It was, I believe, in America that the idea was first expressed that red light was conducive to health, and what was my surprise to find that every pane of glass in one of the buildings of a new hospital was bright red in color. Again, at the Wilhelmina Hospital, an institution of which Vienna may justly be proud, the idea of isolation of buildings is carried to an absurd extreme. This hospital of less than 300 beds is a group of not less than 20 buildings which have no connection with each other by tunnel or corridor, and many of them not even by telephone. Some of these buildings contain fifty, some six and others even but two patients. The medical staff is emphatic in their denunciation of this "model" hospital, and told amusing instances of the difficulty to locate doctors in a case of emergency. Certainly the maintenance of such a plant is unnecessarily expensive. And, lastly, there is little gain in planning a hospital in advance of the ideas of the doctors and nurses who are to run it. For instance, in a new medical clinic in Vienna I asked for the bed tables which are so conspicuous in England and Northern Germany, and was told that they had none. Later, however, I was shown a pile of them stacked in a store-room where they had lain unpacked for nearly two years. Their use had not been discovered. This

same medical clinic has a very complete and modern installation for hydrotherapy. It was the superintendent of this building who demonstrated it to me. She pointed with pride to a large shower bath, and then standing directly beneath it calmly turned on the water. The effect was of course a very wet and embarrassed superintendent. She then confessed that, although she had been in charge of that building for two years, she had never before had occasion to turn on the water.

In Italy the wealth of marble used in hospital construction makes a visitor from another country envious, and I believe that the marble floors and walls, the marble tubs, even the marble vegetable sinks, may explain the relative freedom from hospital epidemics, for one would think that every other condition was favorable to the spread of the disease. These hospitals are exceedingly primitive in plan and are not noted for cleanliness, but they are for economy and in them good work is done.

The hospitals of Budapest were exceedingly interesting, for these ambitious Hungarians have borrowed the best they could find in several countries and introduced some very good ideas, and as a result have hospitals which deserve study.

In our own country, the military hospitals seem still to be the favorite, and the reason is not hard to find, for a very active champion of this plan told me that he had planned over fifty hospitals, many of them during the last few years, and yet confessed that he had not read a book on hospital construction during the past fifteen years.

But let us now draw some rather general conclusions from our study of modern hospitals. The first is a conviction growing now, in Germany at least, that a hospital building is a piece of medical apparatus for use in the treatment of patients. It is not merely a boarding house in which patients are treated. Just as the trained eye after studying some surgical instruments can tell its use and whether it was intended for man, woman or child, so we believe in time the simple examination of a hospital building stripped of all its furniture will reveal to the trained eye whether that building was intended for men, women,

children or infants, whether for chronic or acute cases, whether for medical or surgical cases, etc. This is now possible in some clinics in Germany, but I do not know of any American hospital of which it is true. Again, granting that the building itself is a medical instrument which a certain professor is to use, we should expect this professor to be as whimsical concerning the pattern of this instrument as he is of the pattern of his splints, needle holders, retractors, etc. Of course, buildings cannot be thrown aside as readily as can a forcep of new pattern, but to any one to whom a professor has demonstrated his clinic and has had explained to him the advantage of this or that seemingly trivial detail will appreciate the value of allowing the man who is to use a building to have a share, influenced of course by a sympathetic architect, in its plans. Of course this is possible only in institutions with one head. In the great majority of our American hospitals the doctor has no more to say about the plan of the ward in which lie the patients he is invited to visit, than he has to say of the plan of the private residence where reside the patients who may call him in professionally.

But permit me to mention a few ideas which others have tried. Continental architects have built their hospitals around an interior. They have not, as in Great Britain, planned the exterior and then considered what to do with the inside. The results may not be a handsome building, but it is a serviceable one. A very early point to decide is whether this interior is to contain acute or chronic cases. If the former, the lavatory, diet kitchen and linen closet will be as centrally placed as possible, and scant provision will be made for corridors and waiting rooms for the visitors or sightseers, or for the sun parlor and lounging rooms, which are so important in wards for chronic cases.

A very point to settle concerning a hospital is the ward units. That is, the maximum number of cases of the diseases for which that particular ward is intended, which one head nurse can supervise, and the number of these patients which one pupil nurse can care for. The ward unit should be a multiple of that of one pupil nurse and enough to keep one head nurse busy. Of course one seldom finds just that number of patients in a ward, and yet by observing this

precaution one may avoid the difficulty experienced at the St. Thomas of London, of which some clinics contained but 8 beds, and of the University Hospital of London, where 36 is the unit. In general we found that for acute, 28 was the most acceptable unit and for chronic cases nearer 60.

If the ward is for women, provision should be made in its construction for the evening calls of the husband, for early evening is the only time the average workingman can call and is the very time when nurses and the other patients want him least.

For the wards built for children, simplicity is the keynote. Everything should be in one room if possible and every child should all of the time be under the eye of at least one nurse or attendant. To become convinced of this point one may visit an average American hospital and then the Haubner and Baginski Clinics in Berlin, and then let him see the fine solution of this problem at the Adèle Brody Hospital in Budapest.

The problem of the children's ward is the difficult one. Only a few decades ago hospitals were, because of the epidemics of typhoid and typhus fevers, small-pox, dysentery and erysipelas, dangerous places for patients of all ages. Now for adults, at least the public hospital is safer than the home in the slums. But for young children even the best of hospitals are dangerous. I have been told by those very well qualified to judge that they they believed home, squalid though it may be, is on the whole a safer place. This may be true of Great Britain and America. In the hospitals of these countries epidemics of measles, scarlet fever and gonorrhea still rage. But I believe this is our fault and that hospital construction, if combined with less soft-heartedness and a better special training in the care of patients, will have much to do to prevent these. It is of interest that in Great Britain, where they are so clean from the domestic standpoint, they admit in some of the best institutions that they have on an average of three epidemics a year. In Germany they can boast of but one in seven years, and here they are not clean from the domestic point of view. I do believe that the secret is partly in the use of stone, tiles, terrazzo, etc., instead of wood. Not long

ago I was interested to watch an epidemic of measles in an American children's hospital, the reputation of which was good. Absolutely nothing was done to check this epidemic. Over fifty children caught it, and two of these died. A pathologist was invited to come there to study the etiology of the disease. In the crowded wards of Esherich's clinic in Vienna the appearance of one case means lively movements to check the spread of the disease, and I was told that they have yet to see an epidemic spread beyond the third case.

It is of great interest to study the "box system" of Paris. These are best studied in Les Enfants Malades. In one building each bed is in a glass and iron box which is tight from floor to ceiling and has a tight glass door. In another room the side walls reach to the ceiling, but there is no wall towards the center of the room. In a third room the side walls are but six feet high. We were told that if the nurses preserved the same precaution the three wards seemed equally safe. One may study the more elaborate development of this plan in Brussels, the compromise in Haubner's Clinic in Berlin, and then may study with profit the imaginary partitions of Baginski's Clinic in Berlin, who teaches his nurses to act as if there were partitions between the beds and who claims if they do this the results are just as good as if the bed were enclosed in airtight glass boxes. Surely to prevent ward epidemics requires not alone cleanliness in general, but the "knowing how" as well. I think it is a question of construction largely, and that, thanks to this, German and Italian hospitals escape troubles which the Anglo-Saxon housewife would say they richly deserve.

It may be that in planning a building far too much attention is paid to the arrangement of the small rooms. One can scarcely ever at the start get them just as he wants them. One important advance in recent years in general building methods is to erect a building of which practically only the outside walls and the floors are permanent. The inside partitions dividing the small rooms are of cement and expanded metal and can be easily knocked down and

cheaply rebuilt at another place. The professor may in this way have a new clinic every year or so and at relatively little expense.

There is not much doubt but that in the hospitals of the future relatively less money will be spent on corridors, reception rooms, wall decorations and operating rooms, and more on ward kitchens, lavatories and large sterilizers. It is now generally agreed that visitors are to be discouraged rather than encouraged to come, and that wall decorations interest visitors more than the patients. The beautiful woodwork at the Fever Hospital on Braid's Hill, Edinburgh, and the decorations of the corridors of the Paisley Hospital near Glasgow find no champion among those who use these hospitals. A soft, quiet tint would be as satisfactory to the sick child as the expensive creations of tiles in the St. Thomas in London, and certainly as the even more elaborate pictures on the walls of a room of another London hospital intended for infants under eighteen months of age. And we will admit that the wonderful amphitheaters and operating rooms, these expensive creations of glass, iron and marble, have been much overdone. One such was recently erected in one of our large hospitals. On the day it was opened the professor of surgery in his short address to the crowd of medical students and visiting doctors said in effect that he did not believe this room would be any more satisfactory than the temporary quarters in a basement where for the past year they had been operating, but style demanded such expensive rooms and hence the outlay.

But in the future much more attention will be paid to the ward kitchens, refrigerators, lavatories and sterilizing rooms, for here is where hospital epidemics are controlled. They will occupy more commodious quarters and they deserve the marble, tiles and glass now wasted in the operating rooms. The sterilizing rooms will be commodious and efficient, and every identical thing which comes out of the ward room will be sterilized. Every patient will be considered as a possible spreader of disease and not only the occasional one after it is too late.

One feature in hospital treatment which is now assuming greater and greater importance is outdoor life. Hospitals without balconies now wheel the bed onto the fire es-

capas, onto the roofs of out-buildings, or into the courts. The newer hospitals, especially those of England, are provided with ample balconies. In Basle they have built an open ward where the children remain the entire summer, and hospitals are now being planned with at least one open ward for use the entire year.

It certainly would be an advantage to all if the American Hospital Association would collect and keep for reference at some central point a collection of hospital plans and descriptions of new hospitals. It has been suggested that the Congressional Library, of Washington, would be a very suitable place for such a collection. Would it not be wise to have as a regular item of business in the conventions of this National Association the presentation and explanation of plans of the hospitals built during the preceding year? Would it not be possible for the official journal of this Association to publish more such plans?

The object of this paper is to aid if possible any movement in hospital construction, and especially that improvement which would result were those planning a new building better able to profit by the experience of others and less liable to merely follow conventional types.

DESCRIPTION OF THE NEW NAVAL HOSPITAL.

North Chicago, Ill.

BY REAR ADMIRAL A. ROSS,
U. S. Navy, North Chicago, Ill.

(Illustrated by Stereopticon)

I have just practically made up my mind that I do not know why I am here. Why an admiral of the United States Navy should come here and talk to this assembly I do not know. And never in my sleepest moments did I ever dream of appearing before the American Hospital Association to try to make the members sit up and take notice.

On my return from a 27,000-mile trip, on which I was engaged in inspecting the naval colliers and the coal handling plants of the world, I reported return to the Chief of the Bureau of Navigation, who gripped my hand, and, walking into the Secretary of the Navy, said: "Here is the officer who will build your plant." I said, "Mr. Secretary, I am not a civil engineer, nor architect, simply a poor devil who goes to sea for a living." He said, "When can you go?" To which reply was made, "Have not made out my report yet, but can go tomorrow morning." He said, "Could you go tonight," and again reply was made: "Can do better than that—can go now," and I went. The only orders received on the whole business were: Proceed to Lake Bluff, make preliminary surveys and prepare plans for the approval of the department. Now, if you can imagine anything that would be apt to take a man off his feet, you can imagine what that meant. The Secretary said, "How much money do you want?" Reply was, "Two

million dollars for a starter," and the buildings which will be thrown upon the screen have been built for two million dollars. There are thirteen million cubic feet at a cost of eighteen cents a cubic foot, and, as I remarked before the committee of Congress, "If you can do any better than that with any group of buildings that you put up, I would like to see them." So, at the command, I proceeded to Lake Bluff, made the preliminary surveys, with the able assistance of Civil Engineer Geo. A. McKay, U. S. N., and Jarvis Hunt, architect, prepared the plans of the buildings, which I have the honor to submit for your inspection and criticism.

It was a subject in which I was most deeply interested, having been engaged for sixteen years in the Training Service and Naval Academy, in the great work of bringing up 2,700 of other people's children and one of my own. They seemed to think that, having been successful with the 2,700, this was a job that I had to take hold of. We have been at it now for four years and have now twenty-five buildings practically ready for the Government's occupancy; have thirteen more under way, and the hospital group is now blocking things. It was expected to have the whole institution ready for occupancy on July 1, 1910.

In your circular there is a little mistake in calling attention to the fact that this is a description of the new hospital. The lecture this evening is a display of the whole Naval Training Station subject, because it is a straight hygienic and sanitary proposition from start to finish. The keynote of the whole business is health; that is the golden thread that runs through the web. The Naval Service has had too much experience with infantile diseases, from cerebro-spinal meningitis through all the infectious diseases. We have had our training stations paralyzed with epidemics of mumps, measles, chicken-pox, scarlet fever, cerebro-spinal meningitis and diphtheria. In my own experience, I went to sea in the "Buffalo" with over 800 men, and they were all infected with diphtheria. Had 450 lads, every one of whom took this disease. At times we had as many as 150 cases of the most virulent type. So day by day it proceeded, until one little sawed-off chap came to me and said, "Do you think we are all going to get it?"

I replied, "I think you are; but you hold your luff and you will get through with it all right; as you know, we have only lost two cases in all of the ship's company." With the aid of the best doctors, and the "Good Lord, who is good to the Irish," we pulled through one of the most noted and greatest scourges on board ship that the navy has ever known. It taxed the energies of everybody, and you can imagine what it meant when we would look into a youngster's throat and say to yourself, "Chappie, I don't think you will last through the night." But with 6,000 units of anti-toxin, followed by 6,000 more in the course of twenty-four hours, we had the temperature normal, the throat clear, and in the course of a week had that youngster convalescent. It was a trying moment for all, and the evening might be spent in telling you of the trials and troubles of this cruise. I am very sure that I never want to see another case of diphtheria.

So, with the experience gained, the Naval Training Station was planned and built. There is nothing like it in the world. It is a broad departure from the barrack systems of the world. As a rule, one building is considered sufficient for the housing of men, but in this case six units are considered most desirable. The receiving group, administration, sleeping and toilet, messing, drills, and instruction.

The receiving group is composed of a receiving building, six dormitories, a cook house, laundry and men's club room. We will now take up the buildings in detail.

The lights were here turned out, and the first view was the general plan, or layout of buildings and grounds of the Naval Station, covering 182 acres, the layout being rectangular and the grouping made to cover best the climatic conditions of the Great Lakes. The tract is divided up into four sections.

The receiving group grounds and those allotted the Marine Corps are alongside of the railroad tracts, the main plateau being occupied by the buildings of the main plant and officers' town, and the southeastern section for medical department, main hospital, contagious hospital, laundry, nurse's home and three officers' houses. These different sections are separated by ravines 200 to 350 feet wide, quite heavily wooded from the small stream up and over the

top of the banks. The small stream empties into the harbor which was dug, and 66,000 cubic yards of earth were transferred to fill a ravine now occupied by mess hall and dormitory sites. This harbor, 400x800 feet and a depth of ten feet, will be surrounded by a concrete sea wall, in which will be fitted the necessary davits for hoisting, during the summer, of all boats used in the training of these lads.

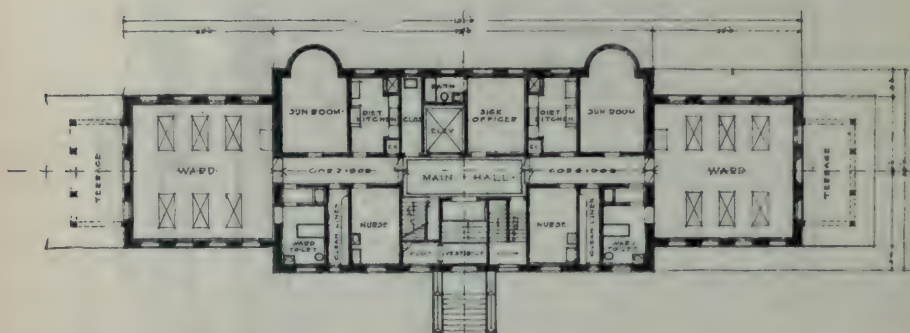
A boat house will be found on the north side of the entrance, 195x86x42 feet, in which will be stored, during the winter, for repairs, painting, etc., all the boats for the institution. Wood-working tools, electrically driven, and the carpenter shop will also be found in this building.

The harbor entrance will be extended into the lake by piers 650 and 700 feet long and 400 feet apart. A crib will be extended to the northward and connected with the power house crib, forming an extension into the lake of about 250 feet; this will be filled up. To the southward this crib will be extended to form the site for the sewage disposal plant. On the northern extension will be found the power house, 125x94 feet, containing all steel working tools, 1,800 horsepower Babcock & Wilcox boilers, 750 kilowatts of electric power, refrigerating and pumping plants. The railroad is run over the roof of this building, coal cars are run out, bottoms lowered, coal dumped into bunkers by gravity over the Roney stokers, and ashes conveyed to dump cars by exhaust system; giving a plant that will require the minimum number of men to attain the greatest economy and efficiency in maintenance. All buildings will be heated by hot water.

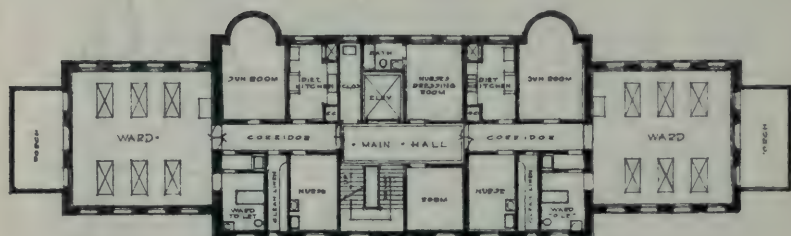
The receiving group is made up of a receiving building on the eastern end of the quadrangle, three dormitories on each side, with the Galley, containing all the cooking outfit, laundry equipment and men's club room in the rear of the northern group.

It is intended to serve the food from the Galley by electric vans to the different dormitories of this group.

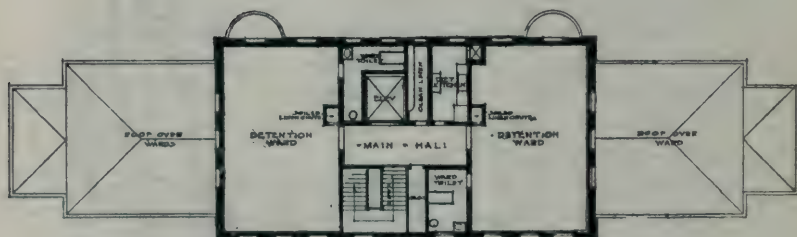
The receiving building is 164x38x37. The center portion has two stories; the upper one provides quarters for arrivals, out of office hours, and for rejections until arrangements can be made for their return to place of enlistment. The recruit enters the main door, turns to the right to the



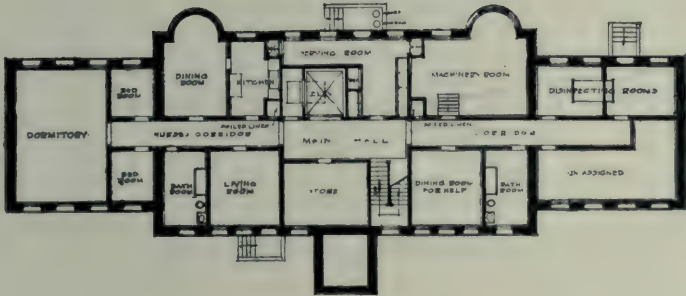
•FIRST FLOOR PLAN•
•CONTAGIOUS WARD HOSPITAL•



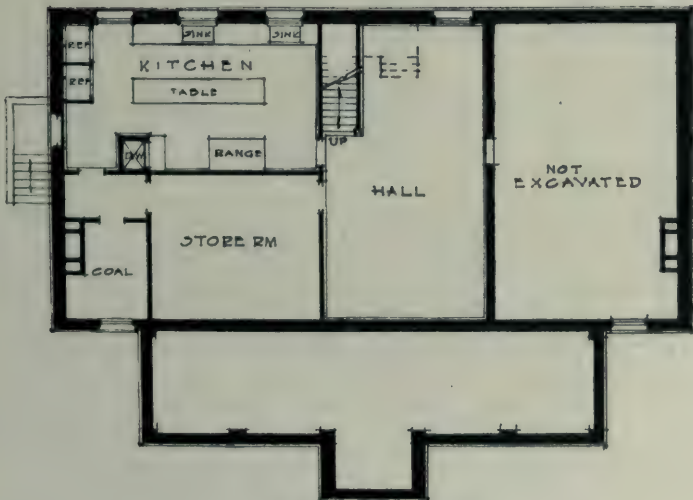
•SECOND FLOOR PLAN•
•CONTAGIOUS WARD HOSPITAL•



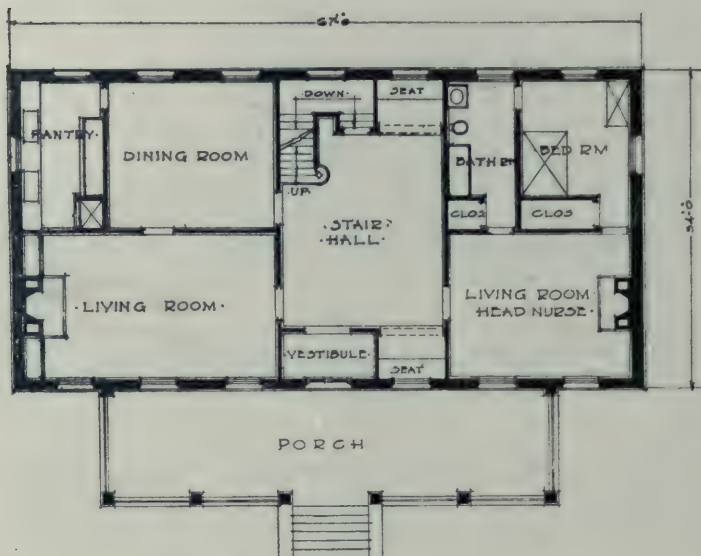
•THIRD FLOOR PLAN•
•CONTAGIOUS WARD HOSPITAL•



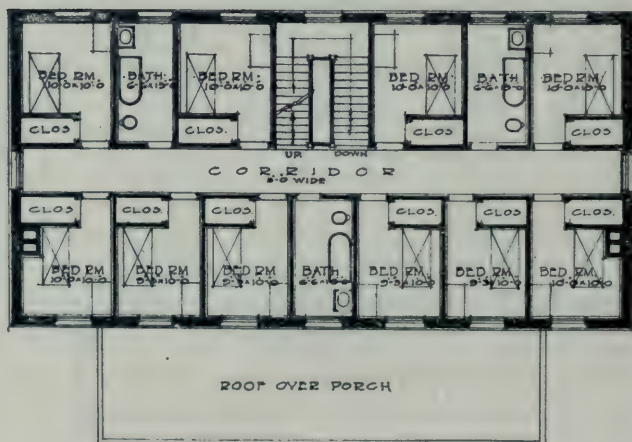
♦ BASEMENT PLAN
♦ CONTAGIOUS WARD-HOSPITAL



♦ BASEMENT PLAN ♦
♦ NURSES HOME ♦



• FIRST FLOOR PLAN •
• NURSES' HOME •



SECOND FLOOR
NURSES' HOME

desk of a petty officer, who examines his papers to see if he is the lad in question. If satisfactory, he proceeds to the next room, a barber shop, where he is shaven and shorn, then to the disrobing room, where he sheds his clothes; these are sent at once to the room adjoining, containing the fumigating plant. He, in nature's garb, goes to the bathroom, where he is soaked and scrubbed, then to the examining room, where the doctor gives him the second examination. If worth raising, he proceeds to the paymaster, where he is fitted out in naval uniform. In case of rejection he goes to the upper floor and awaits the fumigation of his clothing, and when arrangements have been made he is sent to his home. He has had, however, a shave, haircut and bath at government expense.

From the paymaster our lad goes to the dormitory, where he joins a group of twelve lads. There are 50 persons in this building, which is 102 feet by 43 feet 6 inches, and it contains sleeping rooms, living rooms, toilet, baths and pantry. Segregation in groups of twelve is the rule in this group, which was so planned to afford the best method of inspection and care during the month so held—to prove that none of the infantile diseases exist, such as mumps, measles, chickenpox, etc. At the end of the month, if free from disease, these groups of twelve will be transferred to the main dormitory, 191 feet 8 inches by 86 feet by 52 feet, planned and arranged to accommodate 250 lads and eight petty officers. The basement is devoted to toilet rooms in the end wings, entrances all on outside, requiring passage through the open air; scrub rooms are under main portion of building and contain wash bowls, driers, showers and towel booths.

After scrubbing clothes and persons, inspection is held upon both, the clothes hung up in driers, and then the facilities are afforded for showering 250 at one time. Towels are obtained at the towel booths and when used are dropped into baskets and sent to laundry. The only articles laundried are towels and blankets; all other clothes must be scrubbed by each recruit.

On the first floor the central room contains the clothes lockers, arranged as a dado around the walls. They are of pressed steel. The upper one contains rain clothes, the

middle one the ditty box, and the lower, with lock doors, contains a jackstay on which is hung the clothes bag, between two hooks, one for rubber boots and the other for overcoat. In the wings are the hammock racks for 66 recruits, the emergency night closets and petty officers' rooms. These buildings are also planned to be divided by wings or floors, the emergency exits being through the petty officers' rooms. The heating is by hot water; ventilation, plenum system, with separate exhaust system for toilet rooms and basement, exhausting into air at top of room. When dressed, recruits leave dormitories for the day.

The mess hall is 210x229x33 feet, and contains galley and cooks' quarters, seats for 1,000 recruits and 60 petty officers. The galley contains ranges, bakery, pantry, stores and cooks' school, on first floor; in the basement will be found the refrigerating store rooms, beef, pork, butter, eggs and vegetables, brought in on railroad track by carloads. The cooks' quarters are in rear of the galley, and the rear of them, in separate building, the brig, or prison, 83 feet by 48 feet 6 inches by 22 feet 8 inches. All are fitted up with the most sanitary toilet and other appliances.

The drill hall is 401x135x51 feet, and consists of one large room 80x401x51 feet, with rear extension containing ordnance model room, light artillery armory hall, and rooms for doctors, examination, dispensary and dentist. All formations will be held in this building, sick call, etc. The main room is fitted with emergency toilet rooms and racks on walls for 1,000 rifles and equipments. During time not occupied by drills and instruction, 500 men will live here.

The instruction building is 387x120x64 feet. It has two stories, right wing for mental, left for physical culture. Gymnasium and running track are on first floor, swimming pool in basement, 30x90 feet, with lockers, row of tubs and double row of showers, where the youngsters will be tubbed and showered before going into the pool. This is intended for instruction purposes only. The right wing contains a lecture hall that will seat 1,000 men. The middle section contains class and lecture rooms, commissary

stores, boxing and fencing rooms, indoor rifle gallery, bowling alleys, rooms for tailor, shoemaker and barber. Five hundred men will live in this building during the day.

The general store house is 210x66x40 feet and contains offices for general storekeeper, paymaster and commissary; rooms for all supplies, building material, etc.; clothing and small stores, etc., on second floor. A spur track passes along northern side of this building for bringing in stores and supplies by rail.

The parade ground, 1,300x700 feet, is closed on the eastern side by the administration building, and by the dormitories, drill hall, instruction building, general storehouse on northern and western sides. The extension of the plant for an additional unit of 1,000 men is taken care of in the layout for the buildings on the southern and western sides.

The administration building is 224x80x60 feet; height of tower, 156 feet from basement and about 220 feet above lake level. The right wing of this building contains offices for the above extension, the left wing for the plant now built, with the Commandant's offices in central portion, second floor. The great tower shown holds a tank containing 60,000 gallons of filtered water, pumped from the filtration beds and storage chamber just to southward of power house. The water supply will be filtered by slow sand filtration beds; the water to be taken from Lake Michigan, intake one-quarter mile long. We find as good water there as farther out; none of it is safe. All analyses show poor water, and bacterial analyses show colon bacillus. We do not expect any trouble, as we have plenty of land on lake front reclaimed to put in all required filtration beds.

The hospital plans will now be taken up and the slides will present a very fair display of the great work required in their preparation, and the many details that have caused the expenditure of more brain matter than all other sections of this great undertaking.

The hospital site as shown gives a very meagre idea of the beauty of this location. When the Surgeon-General was told that he would be given the choicest portion of the reservation, he was ready to look very closely into the mouth of that gift-horse, and remarked that it would be

the first time that medicine and surgery got the best of a naval land deal. On inspection afterwards he was convinced. The medical officer's houses are on the lake front, seventy feet above the lake. A deep ravine cuts off a portion of the land, leaving a hogback of little use. Fifteen tons of powder will be put under the upper portion and thirty feet of it will be blown into the lake, filling up the site of the sewage disposal plant.

In the second ravine, from the lake, the road will ascend between the officers' houses and the main hospital, which occupies the northern end of the reservation, facing south, with the laundry and nurses' home between it and the main ravine on the north.

The contagious hospital will have the southern side of the reservation, facing north, leaving a beautiful parade ground between them. This tract was quite heavily wooded with ash, red and white oaks, hickory, beech, etc. A great deal of dogwood, hazel, sumac, wild currant and other shrubs cover the parade ground.

The main hospital, 242x94 feet, is, as shown in the slides before you—wings, two-story and basement, central portion three stories; back extension contains kitchen, dining-rooms, and top floor the operating ward. The third floor is used for male nurses and hospital attendants. These plans were completed, but the Surgeon-General sent the order for female nurses, and a complete change was required to meet the new conditions.

The sub-basement floor contains tunnels for heating and lighting mains, hot-water heaters, circulating, receiver, condenser, and brine; pumps and motors, vacuum cleaning apparatus, sterilizing tanks for hot and cold water, elevator machinery, etc.

The basement floor, in wings: Contains fan rooms, laundry, linen and store, hydrotherapy, toilet, service rooms and diet kitchens; two ordinary cells and one padded, laboratory and recreation rooms.

Main basement: Contains kitchen, bakery, pantry, refrigerating and other store rooms, garbage incinerator, dispensary and medical stores, dark room, autopsy, and mortuary with refrigerator; servant's dining-room, toilet rooms and elevator.

First floor, main building: Contains general offices for medical officers, records, reception, nurses' parlor, X-ray and toilet rooms, general mess room and dining-room for male and female nurses, stewards, etc.; pantries and serving rooms in wings, wards for thirty-six beds, solariums, quiet rooms, soiled and clean linen, toilet and bath rooms, diet kitchens and nurses' dressings.

The diet kitchen will have electric cookers and cold air refrigerators, electric dumb waiters, vacuum cleaning system for all halls, rooms and wards. Floors in corridors and wards are of cement tile laid in appropriate patterns and colors; wood work a minimum, all angles coved; ordinary rooms have composition or tile floors, walls enameled; a noiseless elevator will be installed, electrically controlled. All sanitary appliances are to be of latest pattern in style and finish. Drinking fountains will have refrigerating coils instead of ice. Heating by hot water, lighting by alternating current, transformer used when direct current appliances are required. All other appliances will be electrically driven and controlled.

Second floor: Wards, solarium, etc., same as first; main building contains six rooms for the accommodation of sick officers, fitted with bath and toilet for each two, blanket and linen rooms. In extension to the northward you will find the operating ward, with operating room, wash and sterilizing rooms, nurses' and surgeons' dressing rooms; etherizing and recovery rooms, with blanket warmers, floors of vitreous tile and walls of glass, no angles; equipment to be of latest and most approved patterns. All quiet rooms and officers' will be fitted with window guards and doors fitted with locks that nurses only can open from inside; but can be opened from outside by all comers.

Third floor, main building: Fitted for male nurses and hospital stewards, with toilet, bath and store rooms; soiled clothes chutes have been installed, pipes extend to top of roof and are fitted with ventilating cowl; door openings in halls fitted with levers, etc., similar to those used on refrigerating doors. In each room and ward will be found a nickel-plated wire basket, in which a sanitary linen bag is placed, mouth held open by ring. When filled or at

stated intervals, bag will be removed, mouth closed with drawing string and secured, taken to soiled clothes chute and dropped in. At the bottom of chute will be placed a receiving car with lids hinged to open downward, but are returned to closure by springs after passage through of bag; these clothes are sent through fumigating or disinfecting plant to laundry.

Nurses' stations will be as shown in corridors and wards. At each station will be found an indicator with bullseyes and etched numbers corresponding to each bed or room under her charge. The pressure of the button by the patient throws a white light over the bed, or room door, and the etched number, also at telephone booth in main hall, which records time signal was made, and when ten minutes have elapsed informs officer in charge or superintendent of nurses of the display of this signal to which no attention has been paid. The nurse is required to go to room or bed and press a resetting button, which will release all signals. An emergency signal is also installed that will throw a red light, and also extension made to Superintendent of Nurses' room and that of the officer in charge. This also requires the pressure of a resetting button to release the signal as before. This is intended for nurses' use in case of requiring assistance to handle delirious patients.

No bells or buzzers are used on any signals in the hospital. Fire alarms are not used. Persons who require notification will be informed by telephone and appropriate red signals. Should terrazo or cement tile be used in halls or corridors, compressed cork carpeting, or linoleum, will be used in thoroughfares to deaden sound, and relief nurses and hospital attendants all will be required to wear hospital shoes and rubber heels.

The basement is as shown; under the floor a sub-basement was required to receive the heating plant. On account of the distance from the power house, live steam is received, not water, to heaters in the sub-basement, and this circulated through the hospital, medical officers' houses, nurses' home, and last to laundry, where hot water required

for laundry purposes will be used, and the surplus will be returned to the hot well in power plant, thus saving thousands of gallons and resulting in great economy.

The laundry: Two-story building; will be equipped with disinfecting rooms and apparatus through which all clothing will be sent before received in the working rooms; electrically driven machinery will be used. On the second floor will be found the quarters for outside civil help and laundry workers.

The nurses' home: A two-story building, with porches, verandas and paved terrace on east and north sides, will be as shown; basement will contain kitchen, pantry, store-room, toilets and laundry. First floor—Living room, dining room and pantry, superintendent of female nurses, with sitting rooms, bed and toilet rooms. Second floor—Enough rooms for ten female nurses, three toilet rooms conveniently arranged as shown in plan.

Officers' houses are very complete; eight rooms and three toilet rooms in house for medical officer in charge, and six rooms and two toilet rooms in others; paved terrace on south and east sides, with pergolas over them, will make them most attractive.

The contagious hospital is located on south end of reservation, and faces north, three stories and basement in main building, with two stories and basement in wings, which have flat tile roofs connected with wards in main building; third story for convalescents and cases under observation. Character of construction, heating, lighting and ventilation, refrigeration, signals, vacuum cleaning system, diet kitchen, rest rooms, etc., same as in the main hospital.

The wards in wings are divided into three bed wards, which can be increased to four if necessary. On the second floor a room for sick officers is supplied; this will be used when vacant by surgeon in charge. Nurses' quarters are in basement. Special care has been taken to have walls and floors well waterproofed and windows supplied to be the largest possible.

It should be noted that details of admission of the patient, examination, fumigation of clothing, bathing, have been thoroughly worked out. Also details regarding entrance and exit of surgeon and nurses into hospital and wards.

The absence of permanent bath tubs in wards and toilet rooms should also be noted, showers and bath table being used instead.

On the third floor two wards are shown for patients under observation and convalescents, who can have the benefit of the roof garden over the wards. Other patients have the solarium on each floor. The doctors' and nurses' dressing rooms, even to the electric comb, for each ward, will fulfill all of the most stringent conditions of disinfection. They are also large enough for a cot bed in case of patients requiring constant attendance.

A special sewage disposal plant and incinerator will be installed for this building. How far these will be needed will be shown by actual experiment and bacterial analyses of sewage products.

It may be considered by many that there are too many refinements in this building; but it is felt that in the planning and building every contingency should be covered, and that the government cannot go far wrong in building the most efficient and sanitary model that can be obtained in the country.

Thanking you for your kindness and courtesy, I will bid you good-evening.

REPORT OF THE COMMITTEE ON HOSPITAL CONSTRUCTION

DR. H. B. HOWARD.

*Superintendent, Peter Bent Brigham Hospital,
Boston, Mass.*

The broadness of the subject gives your committee great liberty in the method of its treatment. We have not considered it our duty to take up the consideration of various materials for construction. The availability of material and the condition of the finances of an institution generally decide the material of which any given hospital is to be constructed. Nor have we considered definite plans. Plans have to be made for given sites, and must be largely the results of locality. Whether the plan for a given hospital is to be the block or pavilion plan is, as a rule, an adjustment made necessary by the site or the finances of the institution. We shall ignore the general subjects upon which so many books have been written and shall content ourselves with a rambling talk upon the points which at the present day seem to be uppermost in the minds of those constructing hospitals.

Along the broad lines of hospital construction, not much that is new can be said. Certain general principles should always be given their due importance.

Buildings should be so placed as to obtain the maximum of sunlight and air. Deep pockets of more or less dead air, even out-of-doors, are to be avoided. Grounds and gardens about buildings are not only pleasant for convalescent patients but they are to be regarded as large reservoirs from which fresh air sweeps up to, through, and around the separate buildings of an institution properly laid out furnishing it with the real elixir of life.

The terracing of the ward buildings themselves, both endways and sideways, may be used as a means for letting

in sunlight and air to the wards and of throwing the shadows that any building produces to that part of the grounds not occupied by patients.

Better classification calls for smaller wards and it is the task of the planner to see if he cannot so arrange these smaller wards that they can be operated as economically and with as few nurses as the larger wards. There is no question but that an open ward of twenty beds can be handled more economically than twenty separate rooms, but it is still an open question if the large open ward can not be broken up into smaller wards and so arranged that it can be run as cheaply as the large ward.

Ledges at the mop boards, or higher up at the wainscoating, have been practically abolished in the recent hospitals. The abolishment of these ledges is a great tribute to the medical profession. I have listened for hours to architects explaining the impossibilities of doing away with these projections on the walls.

The one thing in hospital construction which seems to be uppermost in the minds of the profession is facilities for giving the patient out-of-door treatment, or treatment with air at its natural temperature. Any one engaged in new construction in the way of hospitals, will have to bear in mind that large verandas or terraces should be built adjacent to their wards and that all doors leading to them from patients' rooms, or from wards, should be large enough to allow beds to roll through them easily. This idea is well carried out in the pavilion wards of the Virchow Hospital in Berlin.

I believe that this open air treatment is more than a hospital fad. I watched its steady growth among physicians, nurses, and patients until I tried sleeping in the open air myself that I might know more about the subject. Having slept in the open for nearly a year, I am willing to admit that there is something attractive and pleasant about it even to the healthy. When you stop to think of it, why should we not be willing to accept and use the air just as nature furnishes it to us in the country.

The ventilation of wards has always been mixed up with the heating of wards. If the wards were hot enough, they

were too frequently considered to be ventilated sufficiently; if too hot they were frequently declared stuffy and ill-ventilated. The tendency at present is to take up the two subjects separately to have sufficient heat where heat is necessary to make the patient comfortable; and to have sufficient fresh air to satisfy the frequently considered exorbitant demands of the attending physician.

The ducts by which air is brought into the ward are receiving more attention than formerly. We now demand that they be straight, and that they be lined with something that can be cleaned so that it will be possible for these ducts to deliver to the patient the clean fresh air that they are supposed to deliver.

Some hospitals have acquired the habit of flushing their wards two or three times a day with fresh air by throwing the windows wide open. In cases where it is thought wise, the patients' heads are covered, and the windows are opened wide after visiting hours, or after the clinic hour, for twenty minutes. This custom gives a delightful freshness to the ward and an agreeable change to the patient.

It is not the intention of this paper to go into an exhaustive argument on any system of ventilation whatever the merits or the demerits of that system may eventually prove to be. However, there seems sufficient reason to have good exhaust ventilation in the group of rooms adjacent to the ward, comprising the serving room, toilets, bath room and laboratory. If these particular rooms are heated by direct heat an exhaust ventilation should be applied to them. It prevents odors escaping from this group of rooms into the corridors and wards, because under these conditions the air will flow towards them away from the corridors and wards. If into the ward itself the air is forced a little faster than it can escape by the avenues afforded, the condition of plenum here furnished prevents any drafts from the windows being felt by the patients. This point seems to be pretty universally indorsed by the engineers studying the problem of hospital ventilation.

It seems to be generally admitted that heating by hot water is much better than heating by steam. Hot water

heating allows a patient to be comfortable in a room when the temperature is five or six degrees under that of the ordinary steam-heated room. I am satisfied that this is true. It seems to be accounted for by the fact that in buildings heated by hot water, the air never comes into contact with a high enough temperature to drive all the moisture out of it. The Johns Hopkins Hospital set the example years ago of heating by hot water, and hospitals contemplating new wards would do well to consider this subject carefully.

In talking about hospital construction we seem to have drifted into talking about the ward. The ward is the important point of the whole hospital. To it everything else should be subordinated and while we are on the subject we will enumerate a few minor points. The ward should be so arranged as to make the distance between the patients and the closets and the slop-hoppers as short as possible. This distance is traversed many times a day by the nurse and the shorter the distance the more efficient the nurse.

Every ward, or every building of wards at least, now demands its own little laboratory. This room should have good flues connected with it where dejections from patients can be saved for the inspection of the physician. This room, when it is supplied, is generally used by the medical side as a laboratory, more or less perfected according to the skill and taste of the attending physician. On the surgical side of a hospital this room is generally converted into a dressing room and the flues of which we speak are used to hold the cans of discarded dressings. It is a useful room for both services and we shall watch its development with interest.

Every ward should have a good blanket warmer. This can be furnished by a small laundry dry bar pushed into a space running parallel with the wall. Perhaps we might as well say the bath room wall, as a hot wall in the bath room is not out of place any time of year. A good blanket warmer does away with the use of hot water bottles which in the best regulated hospitals frequently result disastrously to a patient in collapse or with a sluggish circulation. The

dry bar or blanket warmer can be heated in the summer months by turning through its coils the hot water circulation in ordinary use.

The arrangement for disinfecting typhoid stools, perfected at the Massachusetts General Hospital, seems to have stood satisfactorily the test of two years, as has also the arrangement for disinfecting the dishes used by typhoid patients.

At last we have satisfactory flushometers, so that we can dispense with the flushing tanks for water closets. It is a question if it is not better to attach these flushometers to a tank at the top of the building rather than to the water main, although in some places they have attached them to the water main and pronounce them satisfactory.

The ward bath tub is not used in active general hospitals as much as in insane hospitals, but if the physicians themselves gave the baths, I am sure that the water supply and the waste pipes from these tubs would be so arranged that they would fill and empty the tub much faster than they do. In English hospitals this point is generally well attended to. The waste pipe is large and the supply nozzle frequently has an opening a full inch in diameter. If these are installed right they save much time for the nurse.

A great many superintendents have discussed and experimented with ward floors without improving upon the old standard floor of best rift Southern pine. To us in New England there is a new floor that is coming into more extended use in hospital wards, battleship linoleum (preferably German battleship linoleum) which is cemented or glued to a wood or a cement base. It makes a quiet ward floor, is easy to walk on and the elasticity in it seems to be welcomed by the nurses. It can be polished the same as a wood floor. I said battleship linoleum, because battleship linoleum is made to be cemented down and is thicker than ordinary linoleum. When you get this two meters wide you approach the elimination of all cracks in your floor and the few remaining cracks, or hair breadth lines, are filled with cement. Linoleum, cemented or glued to floors has been used in London and in some parts of Germany for many years. I can show one strip in a Massa-

chusetts institution that was cemented down in the main hall of its Administration building over twenty years ago. When I inspected it last June it did not seem any the worse for wear and the superintendent assured me that it had never been repaired since it had been cemented to the corridor floor in th eighties. This floor has been polished for years, and is beautiful to look at.

The Germans and the Danes have two things connected with their large general hospitals which hospitals in this country rarely have; a building devoted entirely to baths and mechano-therapy. In this building are baths of all kinds; continuous baths, Turkish baths, vapor baths, sand baths, mud baths, Finnish baths, Swedish baths, and the ordinary bathing arrangements as we know them. The mechano-therapy is generally the various modifications of the Zander apparatus.

They have a few points in their kitchen and laundry which are not usually adopted in this country. The laundry washers are so arranged that they can be tilted to be emptied. Some of them can be so tilted that they empty themselves into wheel pans.

Their set kettles are usually made of white or nickerled metal and these kettles can be tilted so they can be emptied or cleaned very easily. At Rome in the Policlinicio Umberto the set kettles are installed or swung between the round standards which apparently come up through the floor. In these standards are the water and steam pipes for the kettles. It made the kitchen appear very neat. This tilting of set kettles not only makes them very easy to ladle from but makes them very easy to clean. It is difficult to clean the bottom of a large set kettle when it cannot be tilted. The tilting in both cases is arranged by a wheel and a screw.

Gas roasters, more common in England than elsewhere, were good to look at, did their work quickly and well, and saved all the juices from the meats.

It too frequently happens that a hospital is constructed without due reference to the housing of its employes. The

effectiveness of a hospital depends largely on the personnel of its employes. Anything that tends to the keeping of efficient persons in the service of the hospital adds to the use and reputation of that hospital in the community. Moreover, employes should be well and pleasantly, and also hygienically, housed.

I can not end this paper without saying a word about the Administration building. Our best hotels work out the problem of their offices so as to do the business of the hotel easily and to make the lobbies pleasant and inviting. The Administration Building of a hospital should be the place for the business. It should be easy of access to visitors and patients. It should be as easy of access as our railroad stations, or hotel lobbies. The main floor should be but one step above the carriage-drive. My reason for saying one step is this, the percentage of feeble people that enter a hospital is very large. The lobby should be of sufficient size to prevent crowding at visiting hours, which are, as a rule, the busiest of the day. Many hospital lobbies are so small that the visitors are taken in through the side doors. In other words, the business of the institution is diverted from the central point instead of being attracted to it.

If the Administration Building of a hospital is large enough so that the patients are admitted through it and are discharged through it, they then can easily come into contact with the resident physician or his assistant. It thus affords them an opportunity of clearing up in a natural easy way any misapprehensions or difficulties that the patient or his friends have had with the hospital during his stay. It is my belief that every patient, where it is possible, should be admitted to the hospital through the office of the institution by the resident physician or by one of his assistants and that patients being discharged should always be brought to the Administration Building, where it is possible, to be inspected. Many of the things complained of during the processes of admission and discharge would have no existence if this custom were usually followed.

DISCUSSION

ADMIRAL ROSS: I am not prepared to accept the latter paper in the interest of hygiene. I can conceive of many reasons why we should have bath tubs. I have seen many patients who object seriously to going under showers, who are not accustomed to it. It is almost impossible to bathe children under shower baths if there is any force of water. I still feel that we should continue using bath tubs, and the showers, as well.

PRESIDENT: Perhaps your people go in head first. The objection to the bath tub is that the feet go in first, as I understood it.

DR. HO..ARD: I went and inspected the particular hospital mentioned some two years ago, and it seemed to me they get their inclined planes easy. They had made very low studded hospitals, in order to make an easy inclined plane. Their main administration building was midway between the first and second floor of the hospital, so that it was a little incline down to the first and a little incline up to the second; and to make that incline much easier they skipped stories. I did not see any arrangement for getting the patients into the open air. The grounds were there, but the difficulties of getting them into the open air were great.

MR. BORDEN, FALL RIVER: There are a good many things in the first paper that was read that did not strike me quite right. I believe that hospitals in our cities ought not to be put out in the woods. The hospital in which I am interested has a great deal to do with people who are injured in accidents. We take care of about a thousand accidents each year, and those people come back, after first attendance, about five times, so that about five thousand visits are made from minor accidents, most of the people coming in street cars or walking. It would be very nice to have the hospital out in a grove, but it would be a good deal of a burden to those 5,000 patients to visit us out and back, if they had to go out in the country. I do not believe in the two-story hospital, because you cannot build a two-story hospital economically on the lot that you can get in a city. The inclined plane proposition is an error. It is a mechanical principle that you cannot lift a body a certain height without the expenditure of a certain amount of horse power—that is a definition of horse power. Every patient going up an inclined plans has got to expend a certain amount of human energy. He spends more time in doing it, and I think he would be very grateful if he had an elevator doing the work for him instead of traveling up and down that inclined plane. Unfortunately, we could not adopt one of the suggestions, which is a very good one, of putting our ground floor approximately on

the level of the street. The grade of the land was such that we had to build it up a certain height. And so in order to let patients get next to the earth once in 'a while, we put an inclined plane from the door down to the ground. It is amusing sometimes to see a little nurse and a big man in a wheel chair negotiating that inclined plane, either up or down; and I am sure that when she lands her patient on the elevator she heaves a sigh of relief. There was another matter which came up—the question of providing recreation rooms for convalescents where they could smoke. I am addicted to the weed myself, and of course when I came to that side of the hospital proposition I had a good deal of sympathy for the poor tobacco lover who was shut up and could not smoke. I have been thrown with the working people of this country more or less, and I find the laboring man who works out of doors, or the sailor man—or anybody who has a great deal of fresh air when he is working, hugs the stove when he is at home. It occurred to me that this was the solution of that problem. When a man is getting well, how are you going to get him out of doors, when he won't go out. He dreads cold air unless working. If my friend wants to smoke, and if he is able to smoke, he should smoke. I therefore combine the two things. I say, "John, if you want to smoke you will have to go out doors," and you get the man out in the air, he gets his smoke. How to solve the woman proposition I do not know, because the most of our women patients do not smoke. Then, there is another proposition, the shower baths, for patients, which struck me as being a novel idea. The superintendent of our hospital, who happens to be here, answered that proposition. She said it is no use having shower baths, because the women won't go into them, on account of wetting their hair, so I guess that ends the shower bath proposition. We must have bath tubs, and as far as I am concerned I would like to get a room with a bath when I go to the hospital. I will trust the superintendent of my hospital to keep that bath tub just as clean as a bath tub that I get into in the New Willard hotel, or any other place. There is another proposition which came up, and that was the question of the disfiguration of buildings by iron balconies. Our theory about that has been that a building that answers the purposes for which it was built looks good to most everybody; so we put airing balconies on the inside of our court yards, and we induced the people to come out on the airing balconies in their beds; if convalescent, we induce them to come out in their wrappers. They don't look handsome, but I think it is the best sort of an advertisement for a hospital, because if they don't look handsome, they look happy, and the stimulus of getting out into the open air is quickly apparent.

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Of course, we lug some out who do not care much about sitting up and taking notice; and we find that bed-ridden people who are feeling pretty good otherwise, are twice as sociable when they get out on the balcony as they are anywhere else. They want the beds pulled up alongside each other, so they can have a bit of gossip. When they are sitting inside the wards they do not feel that way, but the most cheerful people in the hospital are the ones who are out of doors. Putting aside the question of ornamentation, we go further than having airing balconies. We like to have our mattresses aired, and right out in front of our hospital we put racks for mattresses. A mattress hanging over a balcony railing does not look just right, because a balcony railing is not the place to hang a mattress, but when you have a place made for that mattress and put the mattress on top of that, it looks all right, and nobody is shocked by it at all. Those racks are made of gas pipe; and, by the way, a gas pipe is a most interesting proposition. In the first place, we made mattress racks out of gas pipe. In our accident room we wanted tables for three or four patients at a time. We made a nest of tables out of gas pipes. We wanted a foot heater. We took a couple of bicycle wheels, and made the rest out of gas pipe. We have a movable hot table in the diet kitchen that is made out of gas pipe, covered over with sheet metal. All the interesting things about gas pipe have not yet been fully developed, I am sure. The mention of linoleum, as something new in the matter of hospital floors, has been made here. I think that the hospital in which I am interested was the first one to go into the question of linoleum flooring to any appreciable extent, and it is practically just a year that we have tried it. It may be interesting to the superintendents here to learn something of our history with regard to linoleum floors. In the first place the construction of the flooring: Our floors are flat concrete. We laid the rough concrete floors. Then we put the wooden bases in, then we smoothed it so that the wooden bases would project just the width of the linoleum above this smooth finish. Then we cut the battle-ship linoleum in large sheets, cemented it down to the floor so that it came just flush with the wooden bases. The result is that there is no sign of wear in that linoleum. It is not readily affected by heat or intense cold, is soft for nurses to work upon, and practically noiseless. There are only two objections that I have been able to discover about it. In the first place, when it is dirty it looks dirty. I do not know that that is an objection in the hospital, because if you spend time enough on it you will keep it clean; if it is not clean it won't look clean, and that is all there is about it. One other little proposition that I am a little

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bit curious about, and that is occasionally I will find little holes, 1-16 inch in diameter, where apparently something which is used in the treatment of patients of the hospital has been dropped upon that linoleum and eaten through it. It is not anything that anybody would observe unless they were making a study of the flooring proposition. It was an experiment when we put it down, and personally I have been very much pleased with the success of it. There is one other thing that I would like to speak about. One of the papers here has discussed the relation of the doctor to the architect. I do not believe that there is anybody so thoroughly conversant with hospital construction as the hospital superintendent. I think the paper should have been the hospital superintendent with relation to the architect, rather than the doctor with relation to the architect. Doctors have their own business; they know human anatomy, the construction of the human body, but they do not know much about the construction of hospitals; and you cannot teach them, because they won't take the trouble, thought or interest to learn. I had the pleasure recently to be asked by a doctor, who is building a private hospital for himself, to look over his plans. He had been operating more or less in the hospital in which I am interested. I said, "Now, look here, Doctor, the first thing you want to do is to go up and look over the hospital." He replied, "I have been up there." I said, "You have been up on the operating floor and in your patient's rooms." I took him out, and we started in at the basement. I showed him the closets and ventilating spaces; I showed him the relation of the steam pipes to the ventilating spaces; I showed him the refrigerating apparatus; I showed him the laundry, and he said, "I never knew that there was so much to a hospital before." He was a man that had practically decided on the plans for his hospital. It is all right after you have started in to work up your hospital, to submit your plans to the doctors, and get their ideas; adopt the ideas of the doctors which are good, and ignore them if they are bad, because you will get more ideas which when sifted out do not amount to anything, than you can shake a stick at. Do not let them govern the building of the hospital, because they do not know how. The question of municipal government of hospitals is an interesting one. We have a contagious hospital proposition, and naturally enough my suggestions with regard to this municipal contagious hospital were ignored. I wish I had been able to submit the plans of that hospital to some authoritative committee of the American Hospital Association, so that the committee could have said to the board of health which was approving those plans, "You are all wrong. You are spending money at a great disadvantage, and you are in-

juring the lives of patients that are coming to that hospital." As an individual, I had no standing. If there was a committee to which we could refer the matter to, and get an authoritative opinion from experts in this matter, I think a great many mistakes would be avoided in the construction of buildings.

MR. E. F. STEVENS, BOSTON: While I am not a member of this association, I am very much interested in its work. The first writer forgot some very essential points, the provision of airing balconies, the provision for sunlight, the proportion of the windows to the wards, and ready means of exit. The inclined planes, I think, in some hospitals may be very good, but the suggestion of the effort of wheeling a patient up or down these inclined planes, is so great that they lose their value completely. The only place where I have ever seen them used to any advantage is in the hospital in Boston Harbor, where the crippled children are able to go up and down these inclined planes and in that way avoid using the elevator. I will not take the time to discuss all these points, but they are vitally interesting to me. The minute interior details and fixtures and fittings of the hospital. So much depends on every little item of hospital furnishings, in order to provide the best care for the patients and ease in administration. The crockery cases, if they are kept so they can be cleaned from all sides are much better than if they are fastened to the wall. Make the cases movable as far as possible.

The relation of the architect to the building committee, or to the superintendent, is also of vital importance to me. It seems to me that the architect ought to go through the hospitals and see the nurse when she is ministering to the patient, see where the little things might be improved, or some little fixture might be devised which would make certain work easier of administration. The architect should attend the clinics, and see the operations. He should not view it from the outside. In planning a hospital the attention of the architect should not be devoted to the outside altogether, but he should devote himself especially to the interior and its efficiency in the caring for the patients.

PRESIDENT: This has been an intensely interesting and practical subject, and I think it would be well for anybody who wants to ask questions to jot them down now and put them in the question box tomorrow morning, thus bringing up the matters they are interested in at that time.

Adjourned until Thursday morning, 10 A. M.

WHAT DO JUSTICE AND PRESENT CONDITIONS DEMAND IN THE WAY OF LAW AND OF EDUCATION FOR NURSES.*

BY R. M. PHELPS, M.D.,

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It is my design to devote the space of this paper to a discussion as to the proper amount of education, and the proper amount of law that should be demanded for nurses. Many times in the past, after some heated discussion was all over, it has at the last stood revealed that the whole debate had been due to a difference in initial definition—that if the debaters had made clear their starting ground, there need hardly have been any debate at all. Therefore, admitting that, as regards the training of a nurse, there is now a debate as to whether high requirements or low requirements are in a law most just, I am led to first search and see if both sides have the same definitions—if both start from the same premises. For it is presumably the foundation truth we are after, and not to maintain any partisan position. We are also chiefly concerned with the law as distinct from any requirements of ambition.

I have followed some of the discussions, and think I can see clearly that both sides do not have the same aim. If this be so, it would be clearly idle to enter our discussion till we have clear ideas of what each one wants. It would be as idle as for two men to argue about the methods of getting to Philadelphia, when one man has Boston, and the other man has Washington, in mind.

Proof of these differing aims may be found in most of the discussions, but the papers to be found in last year's report of this association, will do fairly well, and will be those

*Read by Miss Mary L. Reitt.

most familiar. One part of the writers seem to have the following aims: An aim to provide enough pupil nurses for hospital work; an aim to provide enough graduate nurses for private and hospital nursing; an aim to provide such training and instruction as shall make nurses able to care for the sick in such nursing.

The other part of the writers have the following aims: An aim to place some standards and requirements by a law, even if such standard lessen the number of pupils and graduates regulated under such law; an aim to go farther than plain caring for the sick, and make nurses able to conduct tuberculosis work; to take teaching positions; to take charge of hospitals; to do district nursing; to be sanitation inspectors; to oversee tenement houses, department stores, and factories; to have special training for nervous diseases; and, finally, to be educated the more, because of lack of home education, and because of low entrance age. In Miss Nutting's paper all these are mentioned, and are the usual topics woven into any argument for advancing the standard.

To re-state this briefly, one side wishes to train nurses to care for the sick; the other side would add many side branches, specialties, and educational elements. Now here surely is a parting of the ways. One can't travel both roads at once, and there is a world of difference between them. For we must remember that it is not an ideal but a law that we are discussing. An ideal is something judged desirable either as a maximum or even as something beyond the attainable maximum. A law on the other hand is, or should be, the definition of a minimum. It is very evident from the language of the high standard advocates, that it is an ideal and a maximum that they seek or have in mind. They fail to see that a law is always to define and fix a minimum. They do not have so much an aim to "elevate" all nurses, as to get a law which shall elevate certain nurses in the public regard.

Seeing this in this way, I unhesitatingly select the first aim—that of learning to care for the sick, as the reasonable one. And to support this choice of aim I give the following reasons:

1. Not over 5% of nurses the country over (at a guess) enter for other than plain caring for the sick. Probably not over 2% ever go to other work right from their graduation, but get postgraduate experience first.

2. These other forms of work mentioned are specialties, and call for special work and special experience, and sometimes for a special education before beginning them. They would still demand this special experience, even if the nurse had had 3 or 4 years of ordinary hospital training. At any rate it would be impossible, even in three or more years to take *all* of them, and no one knows which one would be needed by each person. Even if it were possible it should not be demanded by law that all nurses should become proficient in all these branches.

3. The vivid statements of Miss Nutting as to the present lack existing in present schools, in one of the most favored states (astonishingly extensive to us), and the statements that schools are obliged to take applicants of less age and less education, argue, to my mind, directly against the advancing of the standard. They practically force admission that there are not enough applicants of the old standards to meet pressing needs, and therefore that any advancing of the standard would still more limit the number of applicants. (In passing, I would like to note that a nurse training school is not in any sense comparable with a literary college. One is a technical training to do, or practice, nursing work—the other is a school for mental culture and acquirements.) I thus conclude that the ordinary training school is to train nurses to care for the sick—while other works of numerous forms are branches or specialties, postgraduate in character indeed, are, some of them, outside nursing work. Remember again that it is only of the minimum that we are speaking, and of requirements to be made by law. Ambition is allowed free play, and if any specially favored school can find it possible, it may accept only high school graduates, indeed possibly only college graduates. Yet, even while doing so, such school, may, and should, recognize clearly that to require such graduation by law of all schools in the United States would be grossly unjust. For a maximum or an ideal should not

become a requirement by law. Indeed it is doubtful, if more than two or three schools in the United States, have actually accepted nothing less than high school graduates during the last three years. Of course, no one has the slightest objection to their so doing.

The only way I could logically justify a law to meet such demand is this: If there be a demand for highly educated nurses (and of course there is such demand in places), and if the demand can only get a supply by the aid of a law, then get a second law which shall establish a "high school grade" of nurses. But let us not attempt the impossibility of obliging all schools to accept only such.

But we are on the subject of a law, and we should study closely to see what laws are for. What justifies any law? At once comes back the ordinary answer—"law is justified by being for the public good." It is common also to say that laws should not exist to elevate an individual or class. Also, it is in accord with well nigh universal precedent and teaching, that any regulation by law shall apply to the whole of a class.

Now, curiously enough, the present laws for nursing, do not accord with any of the above accepted principles. They do not apply regulation to all who nurse; they thus do not protect the public against incompetence; they do not recognize, or even seemingly wish to recognize the great numbers whom the advocates have yet pleased to call the "ignorant, the incompetent and the unscrupulous;" but they do aim to give a title and honor to those in nursing work who already have the highest positions.

Now, I have no personal reasons for bringing up these unpleasant criticisms. I am willing to take back any that are shown wrong. I am perfectly aware that the most easy, comfortable, profitable, and pleasant course is a non-critical one. Indeed, in the beginning, I was rather inclined to overlook portions of those now practicing nursing and favor some of the laws; but after prolonged study, I ask freely and frankly, are not these things so? Are they true? Are they facts? Making all concessions to courtesy, to charitable motives and good intentions, it yet seems to me

that in such a meeting as this, it would be wrong to avoid frank and square critical comment.

All other occupation laws make at least an aim to either "cut out" or bring to grade the least fitted of their members. For example, a law for physicians takes in all, and limits only those least fit. Present nursing laws ignore the least fitted of those who are nursing and allow them full sway unhindered. Indeed still farther than this, these laws not only ignore the least fitted, the non-graduate nurses, but of those who have graduated, and in some of the most prominent states, hardly one-third of the graduates are registered. What name have the rest? Is this not creating a class, and then a class within the class? Is this not a confusion of grades increased?

But, comes the reply "we wish to elevate the standard." We surely can elevate the standard nominally. But a trifling analysis shows that we are lifting *only* the standard—we are not elevating nurses as a whole, nor are we even lifting them as a part. What happens each time the standard is lifted, is that fewer are in the lifted portion. If, as is rumored, at the present time, not one-tenth of all nursing is done by graduates, a little lifting of the standard would provide that not one twentieth would be done by those registered. These fewer nurses may get better pay and honor, but do justice and present conditions demand any such result; or is it the ambition of the few? "Lift the standard," indeed one might, till only one nurse could fill the requirements, if you could get a legislature to pass such a law—but for what good? Surely not for the public good.

Of course the reply may be made to this: "This standard which we desire is good, all should come up to it." Of course the standard is good. All education is good. Of course also all can come up to it in theory. But only in theory. Indeed in theory, every present non-graduate nurse may come up to registration standards. But in practice it is evident that there is no such possibility. A law to that effect may cause a little increase in effort of some nurses, but the underlying economic law of supply and demand is the main governing law, and always will be so. You can

not get very far away from it. If it were not for this economic principle, the standard might be placed anywhere, and we need not stop at a high school graduation. If it were not for this law, a little legislated law, passed however carelessly, might lift each and every occupation up to any ideal, and perfection might approach at once. All occupations are in about equal need of laws, and all might be raised together. The fallacy of all this is too evident to call for more comment.

To state the matter differently, nothing but the fact that any person may nurse unrestrictedly, however ignorant and incompetent, prevents this law, even as it now exists in places, from forming the closest monopoly ever known. This exception, however (not found in any other laws), changes the effect of the law to the giving of a title to a select class, which, again, so far as I know, is without any precedent whatever to justify it.

What have been the results of such laws? Whether they be wholly results or not, if we may judge from reports, prices have risen, and become more rigid; nurse applicants have become too few; nurses of graduate standing have become more exclusively for the richer classes (who in any event may get the best); undergraduate nurses have increased in numbers; the general average education of those nursing has probably not increased; and trained nurses are losing the old ethical ideal of being for all cases, and are shunning the contagious, the disagreeable, and the poor pay cases far more than they used to do. For this latter reason, the so-called "undergrade" nurses are often getting the most difficult, the most critical and responsible cases, and those which must be cared for with the least of outside help. This seems a rather serious commentary. Is this true?

There is another aspect of the making of these laws. Many of the present laws disregard notoriously many of the most prominent of hospital workers. Hospitals, with their schools, are usually established by laymen, and physicians have helped in the establishment and the management of them. The school part has been fostered and conducted largely by the aid of physicians. Facing all this, leading nurses have suddenly found that no man can appreciate them or fitly govern them, or can know what their standards

should be. So, flitting lightly by them all, physicians, hospitals and management, the nurses appeal to the legislature for a law which shall place them beyond any fallible man—even advocating publicly that nurses accept no law at all, rather than one in which a man shall have any control. This is elevating with a vengeance. For they not only get a law certifying to their title and selectness, but insert a clause making eligible for examiners and administrators, only registered nurses, which naturally become those most radical among themselves. We do not believe that either justice or present conditions demand any such move as this. We believe the school, as long as it is a branch of the hospital, should have as representative someone from the hospital management. We believe also that since nurses are to act as helpers to the physicians in their work physicians should be represented in control. We, indeed, hold without fear, that only such representation from hospital and from physicians will accord with justice. Legislators have thought that without any restrictive clause, such law could do no harm, and thus have let the laws through, but there is some harm left even then.

Having spoken thus critically of the present trend of laws, what can I propose constructively? One is hardly justified in even a criticism that is accurate, if there be not some thing better to propose. Both for policy and practicability, I would not propose anything revolutionary, but would put forward the following, as moderate and reasonable from my point of view: 1. I would lower rather than elevate the ordinary requirements for nursing as placed in laws. I would do this to avoid forming a select and privileged class. I would do this to provide more of the so-called "standard nurses," which nurses are surely needed. I would do this also for the public good, because only so doing tends to protect the public as a whole. I would even do it for the self-preservation of the registered class itself, for if this class becomes too small in numbers it can not maintain its own distinctions. I would do this, therefore, on nearly every count that I can mention.

Nor do I fear to state more specifically, that I would not in a law, and for a minimum, demand more than a two years' course, and would allow the superintendents to select

their pupils, according to their general qualities, without any restriction based on their previous education. I fully believe they have selected in the past, are now selecting, and in the future, will select, the best educated of their applicants, after making due allowances for moral qualities, and disposition, reliability, etc. For, remember again, we are not selecting an ideal, but a minimum. Any school may call for any degree of higher education, if there be a demand for it.

2. I would advocate constructively that the ordinary school should still, as in the past, be only obliged to train pupils to care for the sick, and that we should avoid in a law, anything requiring them to train for those things which are specialties, or outside nursing work. I refer to public sanitation, to district nursing, to school nursing, to tenement house visiting, to work as anæsthetist, to work as a surgeon's assistant, to drug room work, to psychopathic work, to social service work, to poorhouse reform, or to any others of the many now being enumerated. None of these are to be prohibited or discouraged. Nurses may be able to enter them more easily than others, but a school minimum should not contain them.

3. I would advocate giving less power to the examiners under such laws. However good the examiners may be, they should not have the power to practically make the law, by ranging up or down its requirements. Of course no nurse has to register; if they were obliged to do so, the power would be appalling, but even with nurses uncom-pelled, the power of examiners is far too extended.

4. I would have the present laws carefully studied with the idea of ultimately, and perhaps gradually, extending the law or other laws to *all* who nurse. There will never be any fundamentally good law till this is done. This will bring up the subject of grades. I recognize perfectly that nurses have shunned this subject. But grades there have been (though not accurately specified) and grades there always will be, because the supply exists to meet the demand.

The registration law, itself has made more grades. Ostensibly it only made the grade "registered nurse." Indirectly there is the grade of those eligible to register,

who do not register, also the grade of those who try to register, but fail, also the grade of the graduates from non-eligible schools. These grades hardly existed in defined shape till this law was placed. No one expects these pupils to stop nursing.

The only new thing we are suggesting then is the recognition of these grades by law. In fact, in order to stand out as a superior class, the registered nurses really need these grades, as compared with those to whom they may let those cases go which do not pay enough, or which are in any other way undesirable. Scientifically and logically, such cases may be fully as needy, and the nurses may have fully as much of responsibility in caring for them. We must acknowledge it true that other occupation laws do not recognize grades. Other such laws simply provide for a minimum requirement to do any work at all. To do this in a nursing law, the minimum would be low indeed. It seems to many that grades are preferable. Minor difficulties would be met in recognizing them by law. But when we see so clearly that grades exist, and are even forming into names and classes, it seems absurd for the law to ignore them as non-existing and attempt no classification.

A side thought. The elevation of standards, and the fewness of those registered work for each other in a sort of vicious circle. That is, the higher requirements call for higher pay and honor, and the higher honor and pay, call for fewer nurses. Each tends to intensify the other. But lower pay nurses are surely demanded. Thus the grades have arisen.

5. We also, in a constructive manner, advocate it as the fitting province of a law to make sure that any specified title, means a specific amount of training. Indeed I have often wondered that someone has not recommended a law which should regulate all schools which attempt to train nurses instead of the graduates. Such law would seem far the easier and more efficient. Even then, however, the remorseless logic of the situation forces me back to say again, that ultimately, only when *all* who nurse, graduate and non-graduate, are regulated, will there be a most efficient law.

A long summary seems not needed. Briefly stated, I have held critically that present laws do *not* work for the public good, do *not* regulate nursing work, do *not* affect or improve those most needing regulation, but tend to form a selected class. Briefly also, I have held constructively, that we ask for a law with requirements low enough to form a fairly large class, a class large enough to avoid monopolistic claims; also, that in all justice, hospitals and physicians should be represented in such legal control; and that, finally, only when every nurse, and specially those *least* fitted, are regulated, will there be the *best* law.

In all this, we are assuming no pessimistic mood. The conclusions seem to us logical and unavoidable. If true, we believe that such truth will ultimately prevail. We are not withholding any due honor to the nurse of today. We believe the nurse has come to stay as an honor and blessing to modern life. But we do not believe there is anything special in her work demanding that ordinary logical action, or ordinary legal principles should be set aside.

DISCUSSION

PRESIDENT: This has been called a men's convention. We set one day aside for the ladies, and I think all the men would be glad to sit back in their seats and listen to the ladies talk on a subject that they know all about, and all have opinions on.

A MEMBER: I would like to hear from Miss Keith. She read the paper and she must have some views in the matter. Does the paper represent her ideas?

MISS KEITH: I read the paper because I was asked to do so by the President, not because it represented my ideas.

A MEMBER FROM MINNEAPOLIS: I would like to say that some one from Minnesota listened to the paper because she had to. I want to ask Dr. Richard O. Beard, of Minneapolis, to tell you what Minnesota thinks about the training of nurses.

MISS KEITH: I am not in a position to make any remarks at all upon the law in Minnesota. The statute in New York state is the only law with which I am familiar, and that, as you all know, is executed by the regents of the University of the State of New York. While the requirements which the regents have from time to time made, occasionally appear onerous, our training schools are

the better for it. The regulations of the Regents have not always appealed to us strongly; but for the working of the law in New York state I have no adverse criticism, whatever. The visit of the Training School Inspector is a pleasant visit. We are always glad to receive that inspector, listen to what she has to say to us, and tell her our troubles in return; and I have nothing to say that is not complimentary to the workings of the law in New York state.

DR. BEARD, MINNEAPOLIS: I am very glad to hear a voice come out of Minnesota on this question, even if it is a reactionary voice, and I am glad of it because it gives Minnesota a chance to make answer, and she makes answer in the person of her great institution, the University of Minnesota. It is very difficult to discuss the paper that we have listened to. It seems to me that Dr. Phelps has got so many different issues in conflict with each other, that it is very difficult for us to logically separate them. He is talking about two things which it seems to me have absolutely nothing to do with each other; or have as little to do with each other as the law which regulates the practice of medicine in any state has to do with the educational opportunities which the teaching institutions of that state may see fit to offer. As I understand it, the profession of nursing is not trying to regulate the teaching of nurses; it is trying to regulate the profession of nursing, and that is an entirely different thing. When we undertake to talk about law we are talking about something, after all, which is nothing more than the expression of the average sense of the community. That average is usually deplorably low. It is nothing more than a consensus of the average principles of conduct in society, and does not represent, as a rule, any high standards. We may all of us have our question in regard to the quality of the laws which have so far been enacted to regulate the practice of the profession of nursing. They are unquestionably immature. The laws which undertook to regulate the practice of medicine twenty-five or thirty years ago were exceedingly crude. The law under which I began to practice medicine in the state of Minnesota was known as the "Old Diploma Law," and it was a very poor one. Minnesota set the type of legislation for more than one-half of the states in the union when she developed her present medical practice act, which has been copied more largely than any other act that has ever been enacted; and I have no doubt that the time will come when we may have something in the way of law regulating the practice of nursing which will be a far better thing than we have now. As a matter of fact it is an educational question, and not a question of police regulation at all. The police power of the State may have

to be exercised to say where the line of fitness of any profession comes in, but that law will never set any standards of training in any profession.

We listened the other day to a paper, a most valuable one, by Mr. Homer Folks, in which he undertook to show us the many-sidedness of the subject of hospital work, and you will remember that he cited seven special points at which the hospital touched the interests of the public. That was a very suggestive paper; it struck some notes of suggestion that were very valuable, but it seems to me that after all it missed the keynote. If you analyze those seven different sides of the hospital problem, you will find that five out of the seven are really one. He said the care of the sick and the cure of the sick; and Dr. Phelps' paper insists upon that as being the one sole reason for the existence and education of the nurse; I do not believe that to be true. The other points he states as the education of the physician, the education of the nurse, the study of disease, the prevention of disease, etc. They simply emphasize the fact of the educational function of the hospital. That educational function of the hospital is exercised in one of its phases in the training of the nurse, and yet, as a matter of fact the hospital has never risen to anything like an appreciation of what that function means. Take it for the most part, and I am well aware that there are some notable exceptions to this rule. I am aware the training schools for nurses have been exploited for the benefit of the hospitals they serve, and that the standards of education in the nursing profession are as low as they are today is simply because of that fact. There has been a good reason for that; it has been just as inevitable as the education of many of the doctors in the past two or three generations has been. There has been so large a demand for nurses, just as there was in the opening up of this great country a large demand for physicians compelling the development of a large number of private medical colleges. It has compelled the development of a large number of training schools for nurses in our hospital system. We have had to make nurses, and we have had to make them to meet the public demand, and to make them quickly, and it goes without saying in the most part in the past we have turned them out half-baked. We have turned out doctors half-baked. It is but a very recent time since we have really begun to train physicians for the science of medicine. It is only beginning to be true that we are training nurses for the profession—not the trade, not the business, but the profession of nursing. The University of Minnesota believes that this is an educational question, and it believes that it is so large an educational question that it is one in

which the university may take a hand; and we have established during the last year in the State of Minnesota the first training school for nurses under strictly university control, as a department of that university. We believe that is where it belongs, and that the hospital is really only incidentally related to this question.

How do we expect to train nurses? What has been said today about the overtraining of the nurse unquestionably has certain aspects of truth. There has been an attempt in the education of the nurse to introduce fads of teaching just as there has been in our public school system. The efforts for the betterment of the nurse have not always been in the right direction, and we believe that the first effort should be at the foundation of things; that what we should seek to do is to attract a better class of women into the profession of nursing. That we can determine by law how much a nurse should know, is to my mind an absurdity. The law can never touch this question. It is purely a question of evolution of the nurse, and we believe that we ought to deal with this question purely from the standpoint of the evolution of the nurse for her own sake. That means, in the first place, preliminary fitness; it means the careful selection of the woman who is to become the candidate; and I am in such broad departure from the things that Dr. Phelps has stated in his paper that I hardly know how to answer him. I won't undertake to say what the training schools should do with reference to preliminary qualifications, but I know one thing that they should do that many of them do not do now, and that is to inquire very much more carefully into the general fitness, not merely the high-school training, but the general fitness of the woman who is to nurse. We are subjecting our nurses in the University Training School not merely to the requirements that they shall present the certificate of a physician, but we are subjecting them, in the first place, to a stringent physical examination, to know whether they are physically fit. We want them to be physically as well as mentally fit for the work that they have to do. The university is prepared to pay and go on paying graduate nurses for its hospital service, just so long as it may be necessary for us to secure for the hospital service a class of nurses who shall be physically, as well as mentally fit. We had thirty-three applicants for our first class,—I have so often heard it said all over the country that the applicants are not equal to the need—and we chose nine out those thirty-three. We have had to contend with the small number; and we have given to that small number effective tests of their physical as well as mental tests for the work. We do establish a minimum requirement that they shall be high school graduates. In establishing the training school

department of the university we subject the matriculants of that school to just exactly the same test as we submit every other matriculant. The minimum requirements for the admission to any department of the university is a high-school graduation of the first grade. We, however, give the preference to women of superior mental training, and one-half—a little over one-half, I think—of the first class that we have admitted have been women of more or less university education. We believe that in selecting a superior class of women we shall lay a foundation which will mean that whatever effort we can expend upon them will be well spent and well given. We believe that the overtrained nurse of today is the nurse who was not fit for the training. There is unquestionably a large class of women in the profession who are overtrained, and they would be overtrained no matter what the measure of their overtraining was, because they were initially unfit.

How are we going to train them? In the first place, we have established a four months' preliminary course of instruction before they enter the hospital. They take that course of instruction in the libraries and lecture rooms of the university proper. That four months' preliminary course will take out of the succeeding years' course very much of the teaching with which those years are now, in my judgment, encumbered. That preliminary course will deal with all that a nurse will need to know. We do not propose to make doctors of them; we do not propose to give them a medical training, but it will deal with all that the nurse needs to know in anatomy, in physiology, in *materia medica*, in bacteriology, as applied to nursing; and in chemistry. We will include a course in physical culture, and there we touch a point which seems to me to be one of importance in the training of the nurse—physical culture provided for the nurse herself, with special reference to making her muscularly adapted to the business that she has to perform. Those of us who have watched new nurses—probationers—in their hospital work, must be aware of how uncultured most of these women are with respect to their muscular movements; how difficult it is to get them to do a given thing and to do it in an effective way; and we believe that by a course in physical culture we can make their movements adapted to the work that they have to perform. We have introduced into this preliminary course, a course in English, in the English department of the university proper, giving them training in composition, abstracting, recording, taking of notes, giving them a certain measure of voice culture, which you will appreciate as being a very important point of training for the nurse; giving in this four months pre-

liminary course some general teaching in the principles and ethics of nursing and in household and hospital economics. At the end of this four months preliminary course of instruction they will take examinations, which they will have to successfully pass in order to be admitted to the hospital. They then go into the hospital for a short probationary term, a term of two months, during which they receive the same general treatment as hospitals usually give to their probationers in the practical principles of nursing. They are given no individual responsibility for patients during that time. The university reserves the right to terminate the studentship at the end of the six months, if the student for any reason shall appear to be unfit. If fit, the nurse is entered for the remaining two and half years of the course, the entire period being no longer than that which is given in most of the training schools of the country today. The course is graded in that two and one-half years, both as to the service in the hospital and with reference to the didactic teaching that is given. It is given exclusively by the faculty of the department of medicine. At the end of each year examinations will be held, and will serve as the basis for continuing the course of study; and at the end of the third year the university will give a diploma to the nurse and the degree of graduate in nursing. We hope that by the influence of the University of Minnesota we can do something to elevate the profession of nursing in the Northwest. We want to do it from the educational point of view. We never can do it from the legal point of view. We want to do it by making the nurse specifically more fit for the work that she undertakes to do, and I want to suggest here, in conclusion, that this is the proper work of the State. It seems to me we have not yet arrived at the full, large conception that we ought to reach of what the function of a hospital is: simply one phase of the public duty to preserve and to cultivate the public health. It is just as much the business of the State to make able-bodied citizens as it is the business of the State to try to cure moral and mental lapses of the citizen. As a matter of fact we talk a great deal about our charities in hospitals, and something has been said in deprecation of the municipal hospital, which merely means that we have not yet come to an appreciation of what the business of the hospital is, whether private or public. Every hospital should be a contribution to the education of the people and it is because of this view that we believe that the State as an educational influence should undertake the training of the nurse, to try to make the nurse fit for her business. As a matter of fact, the view that has been suggested of this business in this paper today is a view which seems to be inspired by the general estimate that

society unfortunately still puts upon the whole work of women. Why, such a paper, such views as expressed, such suggestions as it makes of the limitation of a given profession would never be tolerated, gentlemen, for one instant, if you were discussing a business or profession for men. All woman's work has been throughout the long past and is today, sacrificial, but is more essentially sacrificial than almost any other work she does, because it is superior even to the work of the mother in the home who is doing the work for her own, whereas the nurse is doing it for someone else's own; but it is the tincture of that sacrificial quality in woman's work that inspires, in my judgment, an expression of such views as we have listened to today. It means the idea of keeping the woman's profession within certain restricted limits, instead of giving it free way to evolve, develop itself. It is going to develop itself, no matter what you may say or what you may think about it, and we are never going to hedge it in by any fiat of "Thus far thou shalt go and no farther," nor by any law which will seek to limit the evolution of the nurse.

MISS ANDERSON: I want to say that I sympathize fully with every word of Dr. Phelps' paper; I would go farther and say that I believe that no legislation is necessary to regulate the nursing profession. The speaker who has just closed has spoken of nursing as a profession, and the sacrificial tendency of nurses. In contradistinction of that I will mention a story I read only a short time ago from the By-laws of the Registry of Nurses, connected with one of the large eastern hospitals. The graduates of that school who have received their diplomas are not allowed to register in this registry, which is the official register of that school, unless they are registered nurses. That is trade-unionism rather than professionalism. I doubt if you will find any such law as that in connection with any other profession.

PRESIDENT: Is there not some one else here who wants to be heard? I know the men at large do not generally dare to get into a thing of this sort. We would be very glad to hear from anybody. I think we have ten or fifteen more minutes to devote to this subject if anybody cares to speak. If not, I want to get the permission of the members of the Association to allow Dr. Ross who was down on the programme tomorrow to read a report on Hospital Efficiency, Hospital Finance, and Economics of Administration.

REPORT OF SPECIAL TRAINING SCHOOL COMMITTEE

TO THE AMERICAN HOSPITAL ASSOCIATION :

Your Committee, appointed by the President, begs to report on the following resolutions referred to it by the Association :

Resolved, That a committee be appointed, consisting of seven members of this organization and the President ex-officio, whose duty it shall be:

First: To seek information from leading physicians, surgeons, nurses and training school committees, and from every available source, bearing upon the curriculum and length of the course of training of our nurses.

Second: To consider to what extent hospitals should undertake to prepare a class of nurse helpers or assistants.

Third: To prepare a model curriculum, containing only such subjects as they deem necessary for the proper training of a regular nurse or nurse helper, and to report at the next annual meeting of this Association.

Resolved, further, That the Treasurer be authorized to pay the expenses of said Committee, the amount to be determined upon at this meeting.

INTRODUCTORY.

At the tenth annual conference of the American Hospital Association the report of the Sub-Committee on the Training of Nurses was made by Rev. A. S. Kavanaugh, Superintendent, Methodist Episcopal Hospital, Brooklyn, N. Y. In line with the recommendations of the Sub-Committee, the above resolutions, after some discussion, were adopted.

Dr. John M. Peters, President-elect, appointed the following members of the Association as a special Training School Committee, to carry out the intent of the resolutions: Dr. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.; Dr. Frederic A. Washburn, Massachusetts General Hospital, Boston, Mass.; Dr. J. N. E. Brown, Toronto General Hospital, Toronto, Ont.; Miss Charlotte A. Aikens, 722 Sheridan Avenue, Detroit, Mich.; Miss Mary L. Keith, Rochester City Hospital, Rochester, N. Y.; Miss Mary M. Riddle, Newton Hospital, Newton, Mass.; Dr. W. L. Babcock, The Grace Hospital, Detroit, Mich.

The Committee held its first meeting December 15th and 16th, 1908, in New York City, and elected Dr. Peters, Chairman and Dr. Babcock, Secretary. It held its second and final meeting March 23rd and 24th, 1909, in New York City.

In accordance with the wording of the first resolution, namely: *"To seek information from leading physicians, surgeons, nurses and training school committees, and from every available source, bearing upon the curriculum and length of the course of training of our nurses,"* representatives of various associations, hospital and charity organizations, physicians, etc., were invited to meet the Committee and express their views.

The following invited representatives appeared before the Committee: Miss Adelaide Nutting, Miss A. M. Goodrich, Mrs. Hunter Robb and Miss Clara D. Noyes, representing the Education Committee of the Association of Hospital Training School Superintendents.

Dr. Wm. Mabon and Dr. Wm. L. Russell, representing the training schools of the State Hospitals for the Insane of New York state.

Miss Frances H. Bescherer, representing the Albany Guild for the Care of the Sick.

Mr. Homer Folks and Mr. Courtenay Dinwiddie, representing the New York Committee of the State Charities Aid Association.

Miss A. L. Alline, representing the Training School department of the New York State Regents.

Dr. W. Gilman Thompson, Rev. A. S. Kavanaugh and Dr. C. Irving Fisher also appeared before the Committee and expressed their views on several points under discussion.

Letters were read from several who were unable to attend the meeting of the Committee, namely: Mrs. Caroline C. Talcott, General Secretary, Y. M. C. A., New Haven, Conn.; Dr. A. T. Bristow, New York City; Dr. R. M. Phelps, Rochester State Hospital, Rochester, Minn.; Dr. Alfred Worcester, of the Waltham, Mass., Hospital and Training School for Nurses; Dr. L. M. Palmer, Framingham Hospital, South Framingham, Mass.; Dr. Clarence Skinner, Elm City Private Hospital, New Haven, Conn.

Several weeks prior to the last meeting of the Committee a circular letter, covering several of the leading points under discussion, was forwarded to each member of the Association and many other interested parties. About one hundred replies were received and given consideration by the Committee.

The recommendations of this Committee were made after fully considering the needs of both training schools and hospitals, together with such related factors as required consideration. It is not possible in the present state of hospital work to recommend or bring about certain more or less ideal conditions for a training school. The Committee recognizes that it might be desirable to have a preparatory course of several months' duration, the teaching of this course to be conducted outside of the hospital, by trained paid instructors. Such a preparatory course would enable the pupil to approach her practical hospital work with a substantial foundation of knowledge. Many, at present, unsurmountable conditions, educational, professional, financial, etc., prevent carrying out these and other desirable innovations in all hospitals.

In considering the mutual and related interests of hospitals and training schools, it was early recognized by the Committee that general hospitals of from twenty-five to fifty or seventy-five beds could not be considered from the same standpoint as large city institutions of two hundred beds or over, whose functions of late years have broadened and

diversified along special and sociological lines. Owing to this fact the classification of hospitals which follows was found necessary by the Committee in working out a detailed curriculum for the training school. In this division, the Committee has been careful not to lose sight of the interests of the training school as a school or, in other words, has tried to consider the interests of the school apart from the hospital, wherever possible. At the same time the Committee recognizes that the training school is an integral part of and subordinate to the hospital.

CLASSIFICATION OF HOSPITALS.

- (1) Isolated small hospitals.
- (2) Small hospitals, near to, or in affiliation with large general hospitals.
- (3) Special hospitals, including eye and ear, skin and cancer, children's and infants', lying-in, tuberculosis, orthopedic hospitals, etc.; sanatoria for nervous and mental diseases, hospitals for contagious diseases; hospitals for the insane, and hospitals for incurables.
- (4) Large general hospitals.

It is the sense of the Committee that hospitals of less than twenty-five beds, which cannot affiliate or maintain some association with larger institutions, on account of their isolation or financial condition, should not attempt to maintain training schools for the training of nurses.

The following general recommendations, to cover all classes of hospitals, were adopted by the Committee:

- (1) That a probationary term of not less than three months be maintained.
- (2) That probationers be admitted in classes, at regular intervals, preferably twice yearly.
- (3) That a preliminary course of study, of not less than three months' duration, be given to each class, such course to include practical demonstrations of general nursing methods.
- (4) That at least two weeks of the preliminary course be given before allowing pupils to assume any nursing responsibility.

(5) That pupil nurses should not be called upon to give more than sixty-three hours per week to their work, including class hours and exclusive of time off duty. Emergency work out of hours, or overtime work, should be repaid pupils as soon as possible. All time lost by illness of pupils should be made up at the end of the course.

(6) That all hospitals which cannot give one of the courses hereinafter outlined, in its entirety, should seek affiliation with other hospitals in the subjects not covered by the class of patients under treatment.

(7) That paid medical instructors should be employed by all hospitals that can afford to employ them. The Committee has ascertained that a few hundred dollars per year will furnish competent paid instructors for the work. Where paid instructors cannot be maintained, arrangements should be made to have the lectures and strictly medical teaching of the school presented by two or three medical men, rather than by a larger number of physicians.

(8) That a vacation of at least two weeks per year, for the two years three months course, and three weeks per year for the three years' course be allowed all pupils during the summer months.

(9) That all hospitals maintaining training schools of any character, including hospitals for the insane, employ a graduate nurse as Superintendent of nurses.

(10) That no hospital should attempt to maintain a training school for nurses if it cannot meet the requirements of the two years three months' minimum course, or arrange affiliations with other hospitals that will provide full equivalents.

(11) That training schools should not be maintained in small hospitals, without at least two paid resident instructors being provided for the teaching of nurses, one of whom must necessarily be Superintendent of the hospital and Principal of the training school. That all hospitals, irrespective of size, have a graduate nurse as night supervisor. This number should be considered the absolute minimum, irrespective of the size of the school.

(12) That many large general hospitals can advantageously establish a course of six or nine months in hospi-

tal economics, administration and institutional nursing. This recommendation is made in response to the great demand for nurses trained in hospital or institutional work, to fill positions in training schools or other hospital departments.

(13) It is recommended to the American Hospital Association that the constitution and by-laws be amended to provide for a permanent Committee on Legislation. It shall be the duty of this Committee to watch the interests of hospitals and training schools in the legislative field and report annually to the Association thereon.

QUALIFICATIONS FOR ADMISSION AS A PROBATIONER TO THE PRELIMINARY COURSE.

- (1) Age, 21 to 35 years.
- (2) Height and weight, average.
- (3) Physical health, sight and hearing should be normal.
- (4) Physical examination should be given candidates before final acceptance to the school, by a physician appointed by the Training School Committee or Hospital.
- (5) Proof of recent vaccination, or vaccination at time of entering the school.
- (6) Presentation of certificate, giving evidence of one year in a high school or its *equivalent*. *Equivalent* may be defined as:
 - (a) Additional educational qualifications.
 - (b) Evidence of further mental training, such as courses in business college, stenography, art, music, etc.
 - (c) Exceptional personal fitness, combined with desirable home training.

It is not expected that any one or all of the above suggested qualifications be accepted in lieu of a common school education. It is suggested that occasional candidates may have qualifications or attributes which might be considered equivalent to the first year of high school study.

An application blank, covering the above necessary qualifications and several other questions that will occur to the Principal, should be devised. It is recommended that a form similar to Appendix A be used for a physician's state-

ment. It may be incorporated as a part of the application blank. Even though the physician's statement be satisfactory, a physical examination should be made by a physician appointed by the Training School Committee or the Hospital at the time of admission to the preliminary course.

CLASS I.

ISOLATED SMALL HOSPITALS.

The Committee recognizes that the training school problem in the isolated small hospital, of from twenty-five to seventy-five beds, is a problem apart from the training school situation in larger institutions. Numerically, this is the largest division of hospitals in the classifications. Hospitals of this size are scattered throughout the entire country. They are most common in the middle west, south and far west, and are less stable in organization than older and larger institutions. They may be municipal, county, private or semi-private in their management, or, as is frequently the case, organized by village or corporate associations. The professional work and medical departments of these hospitals are usually more or less circumscribed in variety and limited to general medicine, general surgery and gynaecology. A moderate number of these hospitals have small obstetrical departments, and a still smaller number have a children's department. Few of the smaller institutions have a contagious department. Many of these hospitals have demonstrated the possibility of maintaining training schools that compare favorably with schools in larger institutions. Properly managed training schools in these institutions are recognized as capable of turning out graduates well qualified for general medical and surgical nursing in private families. Many factors entering into the situation of these schools lead the Committee to recommend a two years three months' course, of which three months shall constitute a definite preliminary course of study.

The term of school training should not be less than thirty-eight weeks per year for the two years three months' minimum course hereinafter outlined.

PRELIMINARY COURSES.

The preliminary schedule as outlined can be used for the two years three months' course in the smaller hospital, or the complete three years' course in the large general hospital. The teaching of these subjects in the preliminary course must of necessity be more or less elementary. It is recommended that the study of the subjects outlined be attempted in a systematic manner. It is not expected that they will be completed during the three months of preliminary training. This course should be amplified and continued throughout the junior year, in association with subjects hereinafter outlined for the first year. This course has been constructed with the hope that it will provide the groundwork of the subsequent practical career of the pupil nurse in the school and in the hospital.

PRELIMINARY COURSE.

- (a) Practice and theory of nursing (elementary).
- (b) Disinfection, sterilization and protection against bacterial diseases (elementary bacteriology).
- (c) Study of common drugs and their administration. (Preferably taught in pharmacy in class sections. See Clinics and Demonstrations, first year, No. 16.)
- (d) Dietetics: Classification of foods, care of foods, cooking of foods, serving of foods. (See Clinics and Demonstrations, first year, No. 15.)
- (e) Hospital ethics.
- (f) Household economy. (See Clinics and Demonstrations, first year, Nos. 1, 2 and 3.)
- (g) Hygiene and sanitation.
- (h) Bandages and Dressings. (See Clinics and Demonstrations, first year, Nos. 9, 10 and 11.)
- (i) Elementary study of anatomy and physiology.

JUNIOR YEAR.

- (a) Continuation of studies of preliminary course.
- (b) General medical and surgical nursing.
- (c) Ward and bedside clinics and demonstrations.

OUTLINE.

CLINICS AND DEMONSTRATIONS (FIRST YEAR).

(1) Beds; bedding; bed-making, with and without patient; management of helpless patients; changing beds; bed-making for operative patients; rubber cushions; bed rests; cradles; arrangement of pillows, etc.; substitutes for hospital appliances.

(2) Sweeping; dusting; preparing room for patient; disinfection of bedding; furniture, etc.; care of patients' clothing in wards and private rooms; disinfection of infected clothing.

(3) Care of linen rooms; refrigerators; bath rooms and appliances, sinks; hoppers; bath-tubs, etc.

(4) Baths—full sponge, to reduce temperatures; foot baths; vapor baths; hot and cold packs.

(5) Administration of rectal injections, for laxative, nutritive, stimulating, astringent purposes; care of appliances; disinfection of excreta.

(6) Vaginal douches; methods of sterilizing appliances; use and care of catheters; vesical douches; rectal and colonic irrigations.

(7) Local hot and cold applications; making of poultices; fomentations, compresses; methods of application; care of hot water bottles; uses and care of ice caps and coils.

(8) Chart keeping; methods of recording beside observations.

(9) Making of bandages—roller, many-tailed, plaster, abdominal, breast; pneumonia jackets.

(10) Methods of applying roller bandages.

(11) Methods of applying other bandages.

(12) Appliances to prepare for ward examinations and dressings; sterilization of ward instruments; nurses' duties during dressings.

(13) Preparation of patients for operation; hand disinfection.

(14) Preparation and care of surgical dressings, sponges, swabs, etc.

(15) Tray setting and food serving; feeding of helpless and delirious patients; management of liquid diet.

(16) Administration of medicines; methods of giving pills, tablets, capsules, powders, oils, fluids; application of plasters, ointments, etc.; use and care of medicine droppers and minim glasses, atomizers, inhalers, hypodermic syringes, etc.; management of inhalations, eye drops, suppositories, etc.

(17) Care of the dead.

(18) Symptomatology—the pulse; correct methods of examining pulse; volume, tension, rhythm, rate, etc.; effect of exercise, emotions, baths, drugs, shock and hemorrhage.

(19) The face in disease—the skin; expression, eyes, mouth, teeth, etc.; variations from normal, care of mouth and teeth; general observations of the body.

(20) Respiration—normal and in respiratory affections.

(21) Pneumonia—respiration, cough and sputum; crisis and lysis explained and charts shown.

(22) Typhoid fever—face, rose spots, temperature charts, changes in temperature and pulse explained; danger signals; prophylactic measures; methods of managing delirious patients, proper restraint, etc.

(23) Specimens of excreta—urine, sputum, feces, etc.; nurses' duties regarding each; importance and general management.

NOTE.—The numbers signify only headings or divisions, and should not be construed to limit the number of demonstrations or clinics.

SECOND YEAR.

LECTURES AND DEMONSTRATIONS.

Accidents and emergencies, including poisonings, two hours.

Fractures and head injuries, one hour.

Preparations of patients for anesthesia and their after care, one hour.

Surgical material, instruments, and operative technique, two hours.

Complication of wounds, two hours.

Infection, inflammation and immunity, one hour.

Care of orthopedic patients, one hour.

- Gynaecology, two hours.
- Diseases of the digestive organs, two hours.
- Diseases of the kidneys, one hour.
- Typhoid fever, two hours.
- General fevers, one hour.
- Tuberculosis, two hours.
- Other diseases of the lungs, two hours.
- Diseases of the heart and circulatory system, one hour.
- Obstetrics, seven hours.
- Contagious, infectious and genito-urinary diseases, three hours.
- Diseases of the skin and morbid growths, one hour.
- Care of infants and sick children, four hours.
- Diseases of the eye, one hour.
- Diseases of the ear, nose and throat, one hour.
- Diseases of the nervous system, insanity and care of delirious patients, two hours.

OUTLINE.

CLINICS AND DEMONSTRATIONS (SECOND AND THIRD YEARS).

- (1) Surgical technique; preparation for operation; nurses' duties during operations.
- (2) Preparation of antiseptic gauzes, ligatures, etc.; preparation for hypodermoclysis; for aspirating; preparation of anesthetist's outfit.
- (3) Management of sutures and ligatures during operation; instruments for common operations.
- (4) Surgical anatomy and surgical positions.
- (5) Surgical specimens—appendix, tumors, cysts, bone, etc.; preparation and general care.
- (6) Methods of preparing patients for examinations; inspection, percussion, auscultation, etc.; abdominal, vaginal, instrumental and non-instrumental.
- (7) Methods of arresting hemorrhage; external, internal.
- (8) Clinic on pulse and affections of the heart and circulatory system.
- (9) Clinic on respiratory affections—pneumonia, pleurisy, asthma, tuberculosis, etc.

(10) Fevers—important symptoms in special cases.

(11) Sepsis—charts shown; important symptoms and nursing points.

(12) Children's diseases—rickets, teeth, general characteristics; skin affections of children; diseases of the eyes, ears, glandular system; comparison of symptoms in children with adults; marasmus; digestive disorders; adenoids, etc.

(13) Orthopedic clinic; bow-legs, Potts' disease; imperfect development; hip-joint disease; spinal curvature; physical exercises; adjustment of braces; extension of apparatus and corrective appliances.

(14) Milk modification for infants according to different formulae; also for fever patients and invalids.

(15) Obstetrical methods; preparation for normal labor; for instrumental delivery; dressing the cord; care of the baby's mouth and eyes; massage of the mother's breasts; use and care of breast pump; application of abdominal and breast binders; bathing and dressing the baby; management of obstetrical emergencies, etc.

(16) Demonstration of ophthalmic methods; washing out the conjunctival sac; applying eye drops to the eye; eye compresses; preparation for ophthalmic operations, dressings, etc.

(17) Nursing methods in aural, mouth and throat cases; preparation of field of operation in such cases; methods of feeding; uses of syringes, sprays, etc.; nasal douches; taking cultures from the throat; instruments for tracheotomy; intubations, care of tube, etc.

(18) The uses of water for remedial purposes; external application; spinal sprays and douches; Schott baths; medicated baths, etc.

(19) Internal application of water; lavage; enteroclysis; preparation for intraveneous infusions, etc.

(20) Massage; demonstration of methods; effleurage; friction; petrissage; tapotement; methods of stroking; management of light and heavy treatments.

(21) Massage; kneading; percussion; general massage; contraindications.

(22) Local massage—legs and abdomen.

(23) Local massage; head and neck.

- (24) Physical exercises; passive and active movements.
- (25) Urine and urinalysis; simple tests for albumen, sugar, acidity, specific gravity, etc.
- (26) First aid methods—bandaging, etc., in case of accident; artificial respiration, etc.
- (27) Management of delirious and insane patients.

NOTE.—The numbers signify only headings or divisions, not the number of demonstrations or clinics. It is hoped that each school will utilize such patients as the institution provides, to give as varied clinical and practical instruction as possible.

It is recommended that, as the facilities and needs of different hospitals vary, several of the above subjects be amplified and others added to suit local requirements. Not less than forty-two hours during the second year should be devoted to the practical teaching of the above subjects. It is recommended that continued and special attention be given, throughout the second year, to dietetics, hygiene and the management of special diseases. It will occasionally occur that patients suffering from some special disease, epidemic, or infection may be brought into the hospital. If possible, they should be made the occasion of special clinics and demonstrations.

The above outline of the two years three months' course should constitute the minimum teaching course in the isolated small hospital. Hospitals that cannot give this schedule in its entirety should arrange affiliations with larger hospitals.

CLASS II.

SMALL HOSPITALS IN PROXIMITY TO LARGE GENERAL HOSPITALS.

The Committee recommends that hospitals of from twenty-five to seventy-five beds, in proximity to larger hospitals or large medical centers, arrange for affiliation with these institutions, for such training school work as cannot be given in the local hospital. Hospitals of this class, which cannot give the three years' maximum course, hereinafter outlined, should arrange their affiliation so as to complete

the three years' course for the pupil. This gives the services of the pupil to the local hospital for at least two years three months, or two years and six months of the course. It is not expected that affiliation will be sought by many hospitals for more than two or three subjects. If affiliation is sought as outlined, the time devoted by pupils of training schools of this class should be considered additional to the minimum schedule recommended for the isolated small hospital. The Committee recommends the following periods of affiliation:

Obstetrics, three months.

Diseases of children, three months.

Contagious diseases (optional), two or three months.

General medicine or general surgery, three to six months.

Eye and ear, orthopedic, or out-patient work, three months.

CLASS III.

SPECIAL HOSPITALS.

This class includes eye and ear, skin and cancer, childrens' and infants', lying-in, tuberculosis, orthopedic hospitals, etc.; sanatoria for nervous and mental diseases, hospitals for contagious diseases, hospitals for incurables and for the insane.

On approaching the subject of training schools for these hospitals, the Committee met with considerable difficulty, incident to the limited character of the work carried on.

The Committee recommends that large hospitals for the insane, giving a two years three months' course, as outlined, seek affiliation or reciprocity with general hospitals, in subjects, which, from lack of material or other reasons, cannot be given in the parent school.

Other special hospitals in this class should seek pupils from general hospitals desiring to affiliate in their specialty or employ graduates. The Committee does not consider that special hospitals, whose clientele is limited to one specialty, are in a position to maintain training schools or to train nurses adequately for general nursing.

CLASS IV.

LARGE GENERAL HOSPITALS.

The Committee recommends a three years' graded course for training schools in hospitals of this class, the course to include a probationary period of three months, including the preliminary course, as stated, of from three to six months, for each class of probationers.

The outline for the three years' graded course assumes that a hospital of seventy-five or more beds offers at least, either at home or by affiliation, nursing in the following departments: Medicine, surgery, obstetrics, and diseases of children.

PRELIMINARY COURSE OF THREE TO SIX MONTHS.

The outline for this course will be found in the two years three months course on page 9. It is expected that the work in the preliminary term of the three years' course be amplified and advanced beyond that of the shorter course.

FIRST YEAR THEORETICAL WORK.

Preliminary course as previously outlined, and in addition:

PRINCIPLES OF NURSING—Thirty hours.

(Class recitations from text-books or by topics or by lectures.)

FEVER NURSING, including contagion, twelve hours.

STUDY OF DRUGS AND THEIR ADMINISTRATION, ten hours.

MEASURING AND DETERMINING BODY FLUIDS, two hours.

REVIEWS AND EXAMINATIONS, four hours.

FIRST YEAR PRACTICAL WORK.

Practical work of the preliminary course (as previously outlined) and in addition:

MEDICAL NURSING—Three to five months.

(Including the nervous and insane, fevers (non-contagious) and all the general medical affections of men and women.

SURGICAL NURSING—Three to five months.

(Including gynecology and orthopedics.)

VACATION, three weeks.

It is recommended that two months of night duty be given in this year, one month in medical and one month in surgical wards.

The practical work of this year is also to be supplemented by bedside clinics and demonstrations as outlined on pages 17 and 18.

SECOND YEAR THEORETICAL WORK.

STUDY OF DRUGS AND THEIR ADMINISTRATION, ten hours.

MASSAGE, one to two hours.

ANATOMY AND PHYSIOLOGY, twelve to twenty hours.

FOODS AND FOOD VALUES, eight to fourteen hours.

BEDSIDE CLINICS OR LECTURES, eight to fourteen hours.

OBSTETRICAL NURSING—

Class recitations, ten to sixteen hours.

Lectures, four to six hours.

Demonstrations included in practical work.

REVIEWS AND EXAMINATIONS, eight hours.

SECOND YEAR PRACTICAL WORK.

OPERATING ROOM EXPERIENCE, two to four months.

NURSING SICK CHILDREN, two to four months.

NURSING SERVICES in the special departments of the hospital, such as—

Department for contagious diseases,

Department for private patients,

Dispensary or out-patient department,

Emergency wards,

Open air department.

Four to five months.

MASSAGE, eight to twelve lessons.

VACATION, three weeks.

Two or three months of night duty are recommended.

The practical work of this year is to be supplemented by bedside clinics and demonstrations as outlined on pages 13 and 14.

THIRD YEAR THEORETICAL WORK.

LECTURES ON SPECIAL SUBJECTS—Six to twelve hours.

Care of the eye,

Care of the ear, nose and throat,

Care of the nervous and insane,
Diseases of the skin and venereal diseases,
Tuberculosis,
Contagions.

Hospitals not treating any class of cases mentioned above will lack in practical work and should devote more time to theory.

ETHICS OF PRIVATE NURSING, six hours.

LECTURES ON SUBJECTS ALLIED TO NURSING—Seven to fourteen hours.

Industrial and living conditions of the community,
Tuberculosis in the community,
Local milk and food supply,
Local charitable resources and relief of needy families,
Social service and charity work,
Settlements, visiting nurse work, school nursing,
Preventive work of Board of Health,
The nurse's obligations to her school, and to her alum-næ association,
Current topics related to nursing.

Lectures on subjects allied to nursing should be given by specialists or experts.

THIRD YEAR PRACTICAL WORK.

OBSTETRICAL NURSING, two to four months.

DIET KITCHEN PRACTICE, including the modification of milk, one to two months.

DISTRICT NURSING UNDER SUPERVISION, on to two months.

EXECUTIVE WORK (for pupils who show fitness), five to six months—

In charge of wards,
In training school office,
As assistant to night supervisor.

VACATION.

One to two months of night duty are recommended.

Each senior pupil should conduct, under supervision, at least one demonstration for the junior class.

The practical work of this year should be supplemented by bedside clinics and demonstrations as outlined on pages 13 and 14.

THE TRAINING OF ASSISTANTS OR ATTENDANTS FOR THE
CARE OF CHRONIC CASES AND THE SICK AMONG
THE POORER CLASSES.

The following was one of the resolutions which forms the basis of the work of the Committee:

"Second: To consider to what extent hospitals should undertake to prepare a class of nurse helpers or assistants."

The Committee would recommend that in future consideration of this subject, the words "nurse helpers" be dropped as a misnomer and the word "attendants" be substituted.

The inquiries of the Committee have clearly demonstrated the fact that there is a great demand in all parts of the country for a class of attendants or nurses with special training and capacity to nurse or care for patients suffering from minor illnesses, chronic diseases, etc., in the great middle class and among the poorer class. In most of the leading cities a small percentage of the needs of the poorer class are met by Visiting Nurse Associations, Guilds for the Care of the Sick, etc. The number of nurses representing these associations is inadequate to cover thoroughly the field in which they are supposed to work. To meet the demand for this class of nursing a large body of "attendants," with a certain degree of training, is necessary. Their capacity and training should enable them to minister to the class of patients designated above, at a rate ranging from \$8.00 to \$15.00 per week.

The following paragraphs express the views of the Committee:

(a) It is the unanimous opinion of the Committee that general hospitals, meeting the requirements of the two years three months' course, or the three years' full course, are not in a position to train attendants (so-called "nurse helpers").

(b) That nurse "attendants" be trained in hospitals too small to maintain a training school, with a proviso that in these hospitals a sufficient number of graduate nurses be employed to take the full responsibility of the care of the sick and that these pupils act only as assistants to the graduates.

(c) That nurse attendants be trained in the chronic wards of large city or municipal hospitals. It is believed that such a training could be given without interfering with the maintenance of a regular training school, whose special province would be the acute wards of these institutions.

(d) That nurse attendants be trained in hospitals for incurables, homes for the aged and in many of the special hospitals designated in Class III of the Committee's classification.

(e) The Committee would further recommend to the Association that a special committee be appointed to fully investigate the subject of the nursing of people of limited means in their homes, and the education of trained attendants for this work; also to prepare an outline curriculum of training for such attendants and report to the Association at the next annual convention.

Signed,

JOHN M. PETERS, M.D., *Chairman.*

W. L. BABCOCK, M.D., *Secretary.*

HENRY M. HURD, M.D.

F. A. WASHBURN, M.D.

J. N. E. BROWN, M.D.

MISS CHARLOTTE A. AIKENS

MISS MARY RIDDLE

MISS MARY L. KEITH

Special Training School Committee.

APPENDIX A.

STATEMENT OF FAMILY PHYSICIAN.

Name of applicant.....
 Exact date of birth.....Height.....Weight.....
 What serious illnesses has the candidate had?.....
 Is she subject to headache?.....
 To throat disorders?.....
 To digestive disorders?.....
 To ovarian or uterine disorders?.....
 What is her heredity, especially in relation to tuberculosis,
 epilepsy, or mental disease?.....
 Are her heart and lungs sound?.....
 Is her menstrual function regular and normal?.....
 Are her teeth in good order?.....
 Breath odorless, or otherwise?.....Complexion?.....
 Are her sight and hearing good?.....
 Has she been successfully vaccinated?.....
 Has she any physical defect, which might interfere with
 the work of nursing?.....
 Have you carefully examined the applicant, and do you
 recommend her admission to the school?.....

Signature.....M. D.

Residence.....

Date.....

The above is for the Training School records.

NOTE.—A physical examination will be made by a physician connected with the Training School before the pupil enters the school.

DISCUSSION

DR. GOLDWATER, NEW YORK: I would like to offer the following resolutions: "That the report be received with the thanks of the Association and the committee discharged; *secondly*, that the report of the committee be accepted and placed on file; and *thirdly*, that the Secretary of the Association be instructed to place a copy of this report in the hands of the superintendent of every hospital and training school in the country, and that copies of the report be sent to the medical and nursing journals."

The motion was duly seconded and carried.

PRESIDENT: You will take up the discussion of the subject matter of this report. I will refer to pages 5 and 6 and if the members have any discussion to offer in line with it, I think that would be the best way for all to follow it. On page 5 is a classification of hospitals.

DR. ROSS, BUFFALO: Before beginning our discussion, it seems to me that we should take care of the final recommendations in the report in reference to nurse assistants. I move that a committee such as is recommended be appointed by the Chair.

PRESIDENT: Would it not be fairer for the incoming President to appoint that committee? He will be a member of that committee, and I should very much prefer to let him have that privilege.

DR. ROSS, BUFFALO: I understand that committees are appointed by the incoming President.

PRESIDENT: You have heard the motion, "That a special committee be appointed to fully investigate the subject of The Nursing of People of Limited Means in their Homes, and the Education of Trained Attendants for This Work; also to prepare an outline curriculum of training for such attendants, and report to the Association at the next annual Convention.

The motion was duly seconded and carried.

PRESIDENT: This is a very important matter. I can speak very heartily for the work done by this committee, and especially the work done by our Secretary. I think all of you will appreciate, who look at the outlines as laid down here, that it meant a great deal of time and a great deal of thought by the individual members of this committee. I think we ought to hear especially from the ladies, the women who have this matter in direct charge in hospitals. I would rather not call on anybody, and if the members will feel free to express their opinions, we would appreciate it. Is there any criticism or suggestion in regard to the Classification of Hospitals given on pages 5 and 6?

DR. ALICE SEABROOK, PHILADELPHIA: In reading over this report before the meeting, I find that there is not a single word to which I cannot personally subscribe, nor do I feel that I have any criticisms to offer or any suggestions to make upon it. I do not see how the committee could have done better work than they have done, and personally and for the Woman's Hospital of Philadelphia, I would like to subscribe to this as it stands.

MR. ROBERTSON, TORONTO: I would like to ask Dr. Babcock, with regard to Class 3, under the head of "Special Hospitals, Including Eye and Ear, Skin and Cancer, Children's and Infants', Lying-in, Tuberculosis, Orthopedic Hospitals, etc.; Sanatoria for Nervous and Mental Diseases, Hospitals for Contagious Diseases; Hospitals for the Insane and Hospitals for Incurables," as to what position the Hospital for Sick Children in Toronto, which is the largest children's hospital in the British Empire, and which has maintained a large training school for 60 or 70 nurses for many years past—I would like to know the position that this hospital will stand in; should it be in the class of Special Hospitals, or should it not be included in the class of large hospitals that maintain training schools?

SECRETARY: The committee considers as large general hospitals, those which maintain a department of medicine and surgery in addition to any other special departments they may have. I would consider the Hospital for Sick Children at Toronto a Special Hospital. The Hospital for Sick Children in Toronto maintains affiliations in those departments which they lack, and have thereby a most excellent training school.

DR. BROWN, TORONTO: Under "Classification of Hospitals" I find, "It is the sense of the committee that hospitals of less than twenty-five beds, which cannot affiliate or maintain some association with larger institutions, should not attempt to maintain training schools." Perhaps some of the members who are here present, or some members of the committee, may have some suggestions as to how such schools should appoint their nurses.

PRESIDENT: I think you will find that covered in Class 2, under "Small Hospitals." The committee recommend, in a broad way, that hospitals of that size do not have training schools; that they be in charge of graduate nurses, for day and night, and that they employ nurse helpers.

DR. EMERSON, CLIFFTON SPRINGS, N. Y.: It seems to me that these small hospitals are hardly getting a fair show in this report. There should be a differentiation made between a hospital with a

medical school, and a hospital without. For eleven years I have been actively interested in nursing education. I know of one hospital in which the nurses get practically no surgical training. There is a crowd of medical students who are obliged to be there, and some of these medical students will come running in at any hour of the night, and when the nurse looks in the ward perhaps she cannot get near the operating table because of the medical students. Those nurses hardly see the dressings in the wards, because there are so many medical students around. It seems to me that a small hospital of only twenty-five beds, if they have an operating room at all, is very likely to give better surgical training to those nurses than this very large hospital which has such a large service and such an active medical school.

A MEMBER: I do not think there is any lack of interest in this audience on this subject, but the truth of the matter is that this committee has done its work so beautifully that it does not leave anything to be criticized. This covers the ground that has been thought out and worked out in some of the best training schools in this country. It seems to me that item by item it is exactly what you would like to adopt and what in many institutions we have adopted, and therefore it does not leave any room for discussion between ourselves. It seems to me the reason we are not saying anything is because there is nothing to say.

PRESIDENT: The Chair will share these boquets with the rest of the committee.

MISS EMMA A. ANDERSON, BOSTON: The superintendent next me expresses an objection to the second clause, thinking it impossible for a school giving a two years and three months' course to admit its pupils in classes twice a year. This would not work out to the best advantage for the hospital, as it would mean that all the more experienced nurses would drop out at one time, leaving the junior or immature nurses in their places. It would be better in the two-year schools to receive new pupils as vacancies occur.

MISS NEDWILL, PHILADELPHIA: I would like to say that in the last year I have found it very helpful to take in my probationers nearly all at one time. I have only a small training school, but I find it very convenient to take in the probationers in the summer months, when my senior nurses have their vacations.

MISS NEVINS, WASHINGTON: I think it would be interesting to know how many superintendents of training schools in this audience here are able to carry out literally the programme, absolutely setting aside that preliminary class for three full months of

the training, and not asking any of them to do the practical work of the hospital. In my own experience, while I fully agree with the idea, I have been able to work this thing out practically and honestly, only by giving this permanent class the actual work of the hospital to do. It seems to me that the trouble with a great many of us is not the lack of applicants, or the proper number of pupils to do the work of that school, but to do justice to the pupil and to give them that preliminary work. It seems to me we cannot ask the pupils to step aside at all. Would it not be interesting and valuable to know how many honestly carry out the recommendation of this pamphlet, that actually set aside the nurses out of the hospital work for three full months before they can do work in the wards or in the supply room or in the dietary?

A MEMBER: As a trustee, I approach this paper with fear and trembling, but there are things in it which relate to the administrative side of the hospital, and one of them is that of the regular admission of classes. It seems to me that we might get no classes, if we graduated a large proportion of our classes of pupil nurses, at a given time, because before the new probationers had proven their worth as probationers we might be very short-handed, if our hospital happened to be full at that particular period. There is another thing which it seems to me may be objectionable with regard to your profession, and that is that as the standard of requirements for admission becomes higher, and the measure of that is the quality of the probationers as they appear, it seems to me that the duty of the superintendent is to cull out the probationers with a very firm hand. Suppose she notifies a class of probationers that they shall appear at a certain time of their probationary period. Suppose that nearly all of these probationers do not probate well; in other words, that she finds it desirable to get rid of a very large portion of them, which I hope will not happen in a great many instances. If she is conscientious and thinks she ought to be governed by the rules laid down in this proposition, she has got to wait six months before she can get a new class. As a matter of fact, as soon as it begins to appear to her that Mary or Jane are not going to make good, it seems to me that the superintendent ought to be looking about for some others that may come in at perhaps a later period—perhaps two or three months later, as the case may be—and when that comes the semi-annual period stipulated here is immediately broken up. I did not have the industry to read this report before I came here, but I was very much struck with the carefulness and the completeness of it. It strikes me there is a difficulty in making too many rules, and if we can eliminate a rule or a precept it would be well

to do so. The work of the hospital has got to be carried on. If there is going to be difficulty because the superintendent does not think that under the rules she could get somebody else for six months, then that raises another difficulty in the hospital proposition.

PRESIDENT: The recommendation is one of the general recommendations, that are stated simply as broad recommendations. I think many hospitals admit classes in periods of three months, four times a year. If the probationers do not make good during that time, there is a chance to get in a second crowd at the end of three months. At the Rhode Island Hospital that is what we have always done.

A MEMBER: That would practically meet the objection which I had to offer with regard to this matter. The three months' probationers would then be supplemented by such few pupils as were necessary to make out the classes. But to wait six months leaves an interim of three months between the termination of the one probationary period and another.

MARY L. KEITH, ROCHESTER: When we first took them in classes, we were very skeptical as to how it was going to work out. We had this same feeling that they might not do well, and we would not have pupils enough to do the nursing. The first year we took them in four classes—four times the first year; then for several years we took them in three classes, three times a year. This is the first year in which we have ventured to take them in twice a year only. But while we approached this proposition with a great deal of fear and trembling, that it would not work out well, that we could not manage so many probationers at one time, and that when they graduated they would all go at one time. Having tried it, nothing would induce us to go back to the other way of taking them in singly. We expected twelve to arrive on the first day of May, and four came. Then we went ahead, and admitted a large class, just as large as we could get together, for the following term, but on the supposition that only about one-third of those that we expected would come. We expected a class of twenty-six on the first day of September, and the entire twenty-six came. Of the twenty-six who came we admitted twenty into the training school, so that our number of pupils for the year averaged up all right, and there has been no interruption in the training school work. As to the pupils coming in at one time and going out at one time, it is not our experience that they do go out on the same day. Nurses lose time on account of illness, on account of being called home, and the time of their actually leaving

the hospital is as widely separated as it was when we took them in whenever there was a vacancy. From being very doubtful as to the wisdom of taking them in classes, we are very strong advocates of it in our hospital.

MR. D. D. TEST, PHILADELPHIA: I think we would all like to testify our appreciation of this committee's work, and there are two points which I would like to emphasize. In the first paragraph, where it recommends not less than three months' probation, I hoped they would recommend more than three months. I doubt very much if the three months' term of probation is just either to the patient or the hospital. In the seventh item, where it recommends paid instructors, I think that is something that all hospitals ought to take up very seriously. This intermittent instruction that has obtained for so many years in many hospitals surely does not turn out the class of nurses that we wish, and the hospitals that have adopted paid instruction have not had to pay out very much money. That question was asked this morning. I would like to say that at the Pennsylvania Hospital we pay instructors and are able to get very clever young men who are making their mark in the world to come year after year.

DR. RUPERT NORTON, BALTIMORE: I did not know when Miss Nevins spoke a moment ago, whether she thought it wise that the nurses should have work or not, but it seems to me that it is not altogether a bad feature that they should be so employed. A great many young girls come to the hospital without knowing in the least what they are going to do, what the difficulties are going to be, and what the pleasant features are going to be. If they could get the simpler work only an hour or two a day during the first three months, it would help a great deal with some of them to find out before the end of the first three months whether they want to remain as nurses or whether they would rather leave. If you put a lot of young girls into the hospital for three months, before you turn them into the wards, you are hardly giving them a fair show to learn what they have got to go through, or the difficulties that they will meet with later.

MISS KEITH, ROCHESTER: I heard an instance only today of a pupil who had gone through the preliminary six months of theoretical work. When she came into the wards the second or third time, she came to the superintendent and said it was an absolute impossibility for her to go on with such work as that, that the theory was all right, but when it came to facing these patients in the beds it was out of the question; she was going home.

DR. W. O. MANN, BOSTON: I do not see how you are going to teach your nurses in three months' time outside of the wards, or how you are going to bathe patients outside of the wards. It is just as well to teach these nurses by letting them go into the wards, comb hair, and give baths, as it is to get some dummy and let them work on that. I should say that the three months' probationary period of practice work should be taught in the wards. Just as Miss Nevins said, a lot of girls know then in a month or two whether they want to stay or not.

MISS KEITH: I do not understand that this report advises keeping them out of the ward. As I understand it the report said they were not to be given nursing responsibility. There was nothing said to the effect that they might not do it under supervision in the wards.

PRESIDENT: I think Class 4 of this recommendation says that at least two weeks of the preliminary course be given before allowing pupils to assume any nursing responsibility. It does not say that the nurses should not work in the wards after the end of two weeks, but we do not think it wise to allow them to work in the wards in any way during the first two weeks.

MISS CHAPMAN, EASTON, MD.: I should like to have a clear understanding from the small hospital point of view. "It is the sense of the committee that hospitals of less than twenty-five beds, which cannot affiliate or maintain some association with larger institutions, on account of their isolation or financial condition, should not attempt to maintain training schools for the training of nurses." Then, again, you say that all hospitals, irrespective of size, shall have a graduate nurse as night supervisor; then, again, you say that nurse attendants should be trained in hospitals too small to maintain a training school, with a proviso that in these hospitals a sufficient number of graduate nurses be employed to take the whole responsibility of the care of the sick, and that these pupils act only as assistants to the graduates. It seems to me that you narrow the small hospital down to a place where you train attendants. You expect to have a night supervisor who is a graduate nurse, and you expect to have enough graduate nurses to do the work, who must be paid. It seems to me that the financial condition there is not clearly understood. Small hospitals, as a rule, have to consider the finances very carefully. If you are only to train attendants for the good of the public and not let them take the responsibility of doing the actual work for the patients, it seems to me we are going to be in difficulty very soon. On the other hand those who have always been in large centers

probably do not know how difficult it is for us to get graduate nurses at any price, particularly the small prices which a small hospital can afford to pay.

SECRETARY: The point made by Miss Chapman is very similar to that made by Dr. Emerson. I may say, and I think all the members of the committee will agree with me, that we met our greatest difficulty on that question. We realize that there are a large number of small hospitals doing most excellent work and maintaining good training schools. It came to our attention in the course of our investigation by the committee that a large number of small hospitals of less than twenty-five beds were trying to train full-fledged nurses sometimes without even a trained nurse at the head. We found a hospital of thirty beds with a matron at the head, who was attempting to train nurses, and she did not have the training herself. There were a number of hospitals of 8, 12 or 15 beds throughout the country, established by some surgeon for his own cases, and they make an attempt to maintain a training school. I do not think we want graduates of schools of that class to compete or attempt to compete with the nurses turned out by the larger schools. We had to draw the line somewhere, and we drew it at the small hospital of twenty-five beds. I know it is a very difficult part of the subject to handle, and for one member of the committee I shall be very glad to hear fuller discussion on that particular subject.

MR. PENDERGRASS, SALT LAKE CITY: I am glad to see these recommendations stamp the disapproval of this association on what we commonly term out west the "Jim-crow" hospital. As the doctor has just said, there are many surgeons, and I believe this especially applies to the western part of the country, who propose to maintain hospitals of their own. In order to operate them as cheaply as possible they start in to run a training school. I know of one where they employ, or where they have three or four nurses in a training school, the head nurse of which was discharged from another hospital for incompetency. I know of another one where the head nurse and her assistants are practically the only nurses there, and they have a training school of one pupil. You can find these throughout the western part of the United States in almost every town you stop in. I think they are a disgrace to the nursing profession; and to accept their graduates as trained nurses, I think, lowers the standard throughout the whole country. I think we cannot do better than to put the stamp of disapproval of this character of work, and I am glad to see the Association's stamp as it does here in this recommendation.

DR. TRUESDALE, FALL RIVER, MASS.: I would endorse most emphatically the opinion expressed by the Secretary and the other gentlemen on this question. It seems to me to be absolutely the duty of the surgeon to maintain his small private hospital without a training school and to give the nurse a complete training is impossible. The best he could hope to have as a finished product would be a prodigy. I think this association should do everything in its power to discourage any effort of that character. I have a small hospital, a private hospital, of twelve beds. I employ a head nurse and five other graduate nurses. In this hospital I believe it is possible for me to do my work better than in any other institution, because I have the nurses trained in my way, and in our work we act as a team. My operating room nurse has assisted me for five years, and she knows my idiosyncrasies, she knows what kind of a needle, what kind of sutures, what kind of sponges I use. The result is that we do what seems to me to be satisfactory team work. When the other question is considered, it seems to me absolutely the duty of the surgeon to attempt to give the nurse a complete training.

MR. DRAPER, ANN ARBOR: I just want to make one inquiry. There are other small private hospitals—I think the Secretary mentioned a New York hospital—where they have an interchange of work, thereby enabling the nurses to complete their course in two hospitals. If it will not be out of the way, I would like it briefly outlined how they do that. I think if I took some of the nurses from private hospitals, I would have to put them on the three months probation before I would be able to put them into the surgical work, or give them the other branches in which that hospital was lacking. I would like to know how the New York Hospital handles that, whether by lectures or change of duty, together with the work done during the lectures. I think we would have quite a problem on our hands to solve. I can heartily agree to all that has been said about these small hospitals graduating the nurse. I do not think a nurse in a small hospital in one special line ought to have a diploma and take a position in any other hospital and be expected to train pupil nurses.

DR. MANN: Mr. Bacon wishes me to speak for him. He says he thinks the committee is very much at fault. They might add something to their report. They have not mentioned these schools that teach nursing by mail.

DR. BABCOCK, SECRETARY: In reply to Dr. Mann, I might say that the committee discussed the correspondence school, but we had no desire to advertise them.

PRESIDENT: In regard to establishing this limit to a twenty-five bed hospital, I appreciate fully the position of many of the people connected with the smaller institutions, but there had to be a limit placed at some point. There was quite a variety of opinion among the members on this, as to just what that low limit should be, and we finally got it down to twenty-five and we could not get any lower. I doubt very much if a nurse could get a general training in a hospital with less than twenty-five beds, unless that hospital was crowded with patients the year round. We will turn now to another feature of the report. We will be glad to hear from any member in regard to the qualifications for admission of probationers to this preliminary course.

DR. HOWARD, BOSTON: When that section referring to the age limit was read, it occurred to me that there was one class of hospitals where we have to take them in younger, that is the children's hospitals. I have been told by different children's hospitals, that they find that the nurses of eighteen to twenty are fully as acceptable, and fully as well adapted to that work as they are older. I think that is true in the Children's Hospital in Boston that is affiliated with the Massachusetts General. In regard to training their nurses, I should say that their nurses appear in all wards rather younger than our nurses. They come to us during the last half of the training period. It has always seemed to me legitimate for the children's hospitals to take their nurses in young. I do not know that this is true throughout the states, but I know at least two where that is done, and they seem to have pretty sound reasons for doing that.

MISS NEDWILL, PHILADELPHIA: Two or three years ago I took charge of the Training School in a hospital of 75 beds. I found we did not have the number of nurses necessary. I found no waiting list and I had to think of ways and means to supply the needs of the hospital. After due consideration and discussion with one of the leading members of the medical staff, we decided to take in the nurses under 21 years of age, or from eighteen upwards, with the understanding that during the two months they were to have a thorough physical examination by the president of the medical staff. I would like to say that I have been able to bring the school up to the full number. We have not had any of the probationers break down in our training school, and I feel sure that I have a class of nurses just as good as if I had waited for nurses who were twenty-one to have applied. I would like to make this plea for nurses under twenty-one years of age.

MISS NEVINS, WASHINGTON: I think Dr. Howard is right in saying that the average child's hospital does accept pupils younger

than the general hospital does, but as I understand it these rules were laid down as an average to include as nearly as possible all hospitals. I think ladies of 18 are too young to start training in a general hospital and prove satisfactory in the end.

PRESIDENT: These matters are recommendations. They are not laws that anybody has got to follow. As I look at it, we were appointed to consider and set a minimum standard such as in our minds would be a proper standard for training schools superintendents or for other people to consider and adopt if they saw fit.

MISS BRENT, TORONTO: We take in nurses from twenty-one to thirty. We have taken in nurses under 21 in exceptional cases, and they have usually been satisfactory.

DR. TRUESDALE, FALL RIVER: I have noticed in the National Hospital Record the advertisement of a hospital in the north-western part of Massachusetts which advertises a post-graduate course for the surgical training of nurses. I would like to know if that meets the approbation of this association. It seems to me to be a feasible plan. It seems to me that courses of three to six months for graduates in the care of laparotomy cases is somewhat appropriate. I find that the average nurse who comes into my hospital to take care of a laparotomy case knows very little about it. I would rather not see her come into the hospital. It seems to me that a post-graduate course of this particular kind is a feasible one.

A MEMBER: I would like to know what hospital those nurses are graduates of that cannot take charge of a laparotomy case.

DR. TRUESDALE: I find that nurses who have been out in their general work in private nursing, taking care of chronic invalids, living largely a life of ease, after a few years do not know how to take care of laparotomy cases. A patient in a certain family will say. Miss So and So has been a nurse in our family for ten or fifteen years. I say, no, she cannot come in here; the girl will be a source of great anxiety on my part; she is not trained to take care of you under these conditions. If you have a nervous breakdown she might be excellent, but I would rather have her come and visit you than to take care of you.

A MEMBER: I think it would be a disgrace to any hospital if a graduate nurse were not able to take care of laparotomy cases after a three years' or even a two years' course of training.

DR. R. O. BEARD, MINNEAPOLIS: While we are in the business of eliminating the hospitals that are unfit to conduct training

schools, I do not know but what we might carry the process of elimination a good deal farther than the twenty-five bed hospital. It seems to have become a sort of tradition. As Chateaubriand said, when the young man told him that he had to live, he did not see the necessity. I am not altogether prepared to see the necessity for every hospital having a training school. There are many things that come out in a discussion of this kind, that tend to show that the hospitals are dreadfully hard up for nurses. What is the matter? The community is not hard up for nurses, the woods are full of nurses. We have a nurse's registry in Minneapolis, with a long waiting list nine-tenths of the year. We have too many. We have too few competent nurses. There are a great many incompetent nurses on the list, and I am sorry to say that is true even of the registry of some of the graduate nurse's associations. Now there is not any paucity of nurses in the community, but the hospitals seem to be short of nurses. I really think that a good many of these small hospitals would find it just as economical to hire nurses as to undertake to train them. As a matter of fact, in a small hospital it is a very expensive thing to train nurses. The more nurses you have to train the more patients you have to take care of and the more economically your hospital can be administered. While we are young in the hospital business, I have had a great deal to do with training schools for twenty-five years and I believe this is actually true, that not merely a hospital of twenty-five beds but a hospital of fifty beds could hire their nurses more cheaply than they could train them. I question very much whether we ought not to deal with this question from an entirely different standpoint. It is that which has brought the profession of nursing where it is. It is that which makes this question of safe preliminary qualifications. It is not the question of what is best for the nurse, but what is best for the hospital from the hospital standpoint. That is not the way this question should be dealt with. It should be dealt with as an educational question, from the standpoint of the good of the nurse. The question of age and every question should rest right there. I believe that in the profession of nursing we are getting to a time similar to that through which the profession of medicine has passed. We had a multitude of medical colleges in competition, constantly reducing the standards of medical education, because they wanted students not because the community wanted doctors. But the time arrived when we had enough doctors, and we came to a time when we slowed up on their education. I feel that we may wisely come to a time when we will slow up in the education of nurses. We have come to a time in medicine when it is true that only two classes of institutions

are fit to teach doctors, those large institutions that are highly endowed and those which are supported by the state. I believe that only those hospitals should train nurses which will come under the same head. They can train nurses properly, they can train nurses economically, they can train nurses upon a basis of their qualifications, and they alone can. The sooner we deal with this question from the standpoint of what is fit for the nurse and get away from the question of what the hospital needs, I believe it will be the better for both.

DR. TRUESDALE, FALL RIVER: It does not seem to me that it is a question of what is best for the hospital, altogether, or a question of what is best for the nurse. It seems to me that in a measure the patient is to be given some consideration. When this subject is gone at in a true educational sense, I believe that the patient will get the benefit. It seems to me that there is no reason why we should not have post-graduate courses for nurses, as well as for surgeons. The man who wishes and who expects to keep abreast of the times in medicine and surgery must be a student practically all the time; he must be visiting other clinics and taking post-graduate work. I do not see that any post-graduate work has been recommended for the nurses.

DR. BEARD, MINNEAPOLIS: I should like to ask the committee whether general recommendation No. 12, referring to post-graduate instruction, is meant as a recommendation to apply to the undergraduate course in the training schools, or whether it contemplates a post-graduate course.

DR. BABCOCK, DETROIT: That recommendation applies to graduates only, and the hospitals that have attempted to give such a course have confined acceptance of candidates to graduates who have been out of the school from two to five years, and know what they want to take up as their life work.

DR. BEARD, MINNEAPOLIS: I supposed that was true. I would like to ask Dr. Babcock another question. Can he give us a reason why the committee recommended that professional medical teaching in the schools should be presented by two or three medical men only?

DR. BABCOCK, DETROIT: I think it is the experience of most superintendents of nurses and superintendents of hospitals that in attempting to distribute the teaching curriculum, over a large number of physicians, about two or three out of fifteen or twenty will prepare themselves and present their work properly to the nurses and that the other seventeen or eighteen do not prepare lectures.

They come and give their lecture, if they give it at all, in a pedantic manner, and the nurse gets very little out of it. The limitation to two or three medical men has in mind the teaching of strictly medical and surgical subjects by two or three medical men who will give the work from the nurse's standpoint.

MISS NEVINS, WASHINGTON: I think all who are interested in the small hospital would agree that to work entirely with graduate nurses is the ideal way. You will not get those nurses into your hospitals for \$100 a month. The difficulty those small hospitals have is in getting the right kind of graduate nurses, as they are not in the financial position to pay a sufficient number, but because they would have to have such a small number that the graduates would be so overworked they would not be willing to stay. The problem is most difficult.

MISS CHAPMAN, EASTON, MD.: I entirely agree that the nurse who is trained two years in the smaller hospital is not fit to cope with a registered nurse from a large institution. But whether the gentlemen from the west like the "Jim-crow" hospital or not, the small hospital is here to stay, and it has to be taken care of. The question on which I made issue was the matter of expense. It is impossible for you to get a nurse that you can use in your hospital for less than \$40 a month. If you are going to have all your work done by graduate nurses you have to have a very wealthy hospital to do it. You cannot get the material even if you want it; they won't come; they do not want to come to do general work in the hospital. But if you have the right material and give them individual attention and training then you can keep them to do the general work. In the pamphlet it says that they should have enough graduate nurses to do all the hospital work. Where does your attendant come in, what is she to do? That is the point I made. I do not think it fair to the general public nor do I think it fair to our profession to turn out a nurse of two years training to cope with a nurse trained in a large general hospital for three years; but that is not the point at all. It is one of practical finance.

DR. TRUESDALE, FALL RIVER: I think the small hospital that cannot be financed, have graduate nurses and pay each nurse more than \$40 a month should be closed. I think it can be done, and it has been done. In the other instance I referred more particularly to the special nurse, who is called in and paid by the patient, not the nurse who is employed regularly by the hospital. I keep five nurses in my hospital, and no nurse is paid less than \$45 a month, and the hospital is successfully financed. I do not refer

to that nurse; I am perfectly satisfied with her work. But I refer to the special nurse who has been out nursing chronic invalids for ten or fifteen years, the woman who has not kept abreast of the work in her profession. She is called in at the expense of the patient, she is given \$21 a week and \$5 for her board, and she is in the way.

DR. RUPERT NORTON, BALTIMORE: Not only the small hospitals cannot afford to pay \$40 or \$45 a month; the large hospitals cannot pay more. In reply to Dr. Beard I would say that while medical schools are diminishing today in number, the hospitals are increasing; they are going to increase. The demands in the hospitals for nurses are increasing all the time. In the large hospitals we have got to have more nurses today than we had twenty years ago; the doctors demand them. We turn out a great many. It is oftentimes hard for a nurse to make a living; I do not deny that. But there are times when there are not enough nurses in a city like Washington, where we employ twice as many nurses as existed formerly. I think there is one question—I do not know whether the committee meant to consider it at all or not—"What is suitable payment for nurses." I think it ought to be taken up and very seriously considered at some future meeting of this association.

PRESIDENT: The work of this committee was in regard to the training of nurses. We thought we had trouble enough of our own.

DR. BEARD, MINNEAPOLIS: I am asked to speak for a lady near me, who is superintendent of a hospital of thirty-five beds, which hospital employs all graduate nurses and makes it pay, although it pays them from \$30 to \$60 a month.

A MEMBER: Is that a private hospital?

DR. BEARD: It is a mixed hospital. It has both pay patients and free patients. It is partly supported by contributions or endowments, as well as by the fees which the patients pay.

DR. ALICE M. SEABROOKE, PHILADELPHIA: One of my neighbors calls attention to the fact that we must not overlook the fact now that it requires about twice as many nurses to take care of the same number of patients as it did half a score of years ago. Our doctors require much more of the nursing profession nowadays, and it takes many more. You must take that into consideration.

PRESIDENT: We will be glad to hear from anyone in regard to the recommendations in reference to proximity to large general

hospitals. I think this question of affiliation is an important one, and somebody ought to have some ideas as to how this could be arranged.

DR. ALICE D. SEABROOKE, PHILADELPHIA: I can only speak for our own personal work in the Women's Hospital of Philadelphia. Some years ago when we wanted to register with the regents in New York, they told us that we were not up to the standard of what they required. We did not have as much general surgery, and of course in a hospital admitting only women, children and infants, we did not have the nursing of men. We made an arrangement with the Polyclinic Hospital, and we exchanged with them. Their pupils come to us for two months only, in obstetrics; our pupils go to them for two months in the emergency dispensary and men's surgery. Their pupils go home for their lectures and classes; our pupils come back to us. We have found it a very satisfactory arrangement on both sides.

MISS NEVINS, WASHINGTON: I do not think we should leave this question of affiliation without another word, because it is an exceedingly important one, in special hospitals. They should ally themselves with the large general hospitals. My experience in regard to affiliation is that the important point is the personality of the superintendent at the head of the hospitals or training schools in those allied institutions. There must be a very clear idea as to the kind of discipline maintained in the original hospital; that the discipline is kept up, that the thing for which the pupil is sent is given. There is often the weakness in sending pupils to the general hospital for a special training; the special training is not always given. She is not given the right course for the time she serves in that hospital. The work of that hospital, we acknowledge, must be done. We admit there is a great deal of drudgery, but there are also privileges to which that nurse is entitled. She is often not allowed the privileges that she should have, and consequently the affiliation fails. It is a question of faithfulness on the part of both superintendents to the needs of the pupil nurse. There must be great conscientiousness to see that the nurse gets what she is sent for, as well as her services. She should have not only the drudgery but as well, the interesting portions.

DR. MANN, BOSTON: In Class 3 the committee refers to a large hospital for the insane affiliating with the general hospital. That came up for our consideration a number of years ago, and we turned the proposition down. We did not think, in the first place, that the class of women in the insane hospital compared

with the class of women we have in a general hospital. They are rougher, they are poorly educated, as a rule, and their ideas of nursing are rather vague. I spent eight years in insane work, and I know what I am talking about on that point. I did not think that we ought to take these women in from the insane hospital, where they are allowed to handle the patients roughly, and put them into a ward with our sick patients.

REV. DR. KAVANAGH, BROOKLYN: There is very grave difficulty on this point. The report has been prepared wisely, and yet, our superintendents of training schools will find it exceedingly difficult in the large general hospitals to receive the nurses from the other hospitals and give them what they desire for this reason: A superintendent or supervisor of nurses has fifty or sixty or seventy of her own nurses. Some of them in the hospital a year, some two years, some have been there less than a year. She has planned her work to give her nurses so many months in the operating room, so many months in the maternity service, and so on through the different departments and the different services of the hospitals. She must care for her own nurses. She has planned her work at the beginning of the year, and at the beginning of their course, and to break away from her plan by giving these outside nurses a place in her scheme of work will not be a very easy thing to do. We have received in our hospitals a number of nurses from outside that needed this special training, and I have always found it was a difficult matter for the supervisor of nurses to properly place them without embarrassing the organization of the school. I do not think this could be drafted in a better form nor more wisely than has been done. But right here we shall have a test of the matter. It will not be done with ease, and where it has been attempted, or in many places at least, there has been very grave unrest in the hospital and dissatisfaction on the part of the nurses.

DR. TRUESDALE, FALL RIVER: During Dr. Howard's administration of the Massachusetts General Hospital, I believe it was the custom to have the nurses in the training school go to Corry Hill Hospital, which is a private hospital, for a short period. I would like to ask Dr. Howard what his experience was with that system. But before he speaks, I want to say that perhaps I was a little severe in criticising the superannuated nurse, but a very practical point came up in the care of laparotomy cases. I would like to know how many of your third year nurses can recognize a case of acute dilation of the stomach, in its incipency? One morning I went into my hospital to make a visit. A patient—she was cared for by a special nurse, a dear friend of her family—

on the second morning after the operation had been given a cup of cocoa. The day before, the first day after the operation, was too early. I could not detect the symptoms of acute dilation of the stomach, but during that night it must have been apparent to any nurse with special training that that patient had acute dilatation of the stomach. The nurse gave her about six ounces of cocoa. Cocoa is very good for a man who is going to chop wood, but you would not give it to a laparotomy-patient in the first week.

DR. TRUESDALE: I asked Dr. Howard what his experience with the training school of Massachusetts General Hospital was, in connection with sending their nurses to Corey Hill Hospital for a period during their course.

DR. HOWARD, BOSTON: I think they liked it. Our nurses liked it, and the Corey Hill nurses liked it. We do not have private patients; we have small wards of eight beds in the General Hospital, where they charge somewhat higher prices, and the idea of sending the nurses to Corry Hill was to train them in private nursing a little more than we could do it there at the hospital. It was to give them a taste of what they have in the outside world. Corey Hill patients were all high-priced patients. I think the Hospital still sends them up there for three months before they graduate, and as far as we know it worked out well.

DR. R. O. BEARD, MINNEAPOLIS: There is another method of affiliation that I want to suggest. The committee suggested an amendment in one clause when it says something about the association with large medical centers. The desirable affiliation is that of a training school with some medical institution, and especially with a medical institution having a large dispensary service. There is a method by which you may supplement the work of your hospitals to very great advantage. We have taken for sometime in the University Dispensary, nurses who come to us to take a term of service in the dispensary, and who serve there anywhere from three weeks to two months in the study and cure of minor ailments, things which the nurse does not see to a great extent in hospitals. From the dispensary we send those nurses out to the care of the sick poor, who constitute the out-patient department of the dispensary, and there they get another line of experience that is quite valuable to them. We intend to develop that phase of our own training school service just as soon as we possibly can. I should think the possibility of affiliation in that direction is quite feasible.

SECRETARY: Your attention is called to the second year's practical work. The committee meant to recommend that four

or five months be devoted to all five of those special departments, not to dispensary work alone, as it might appear in the report.

DR. EMERSON, CLIFTON SPRINGS, N. Y.: The more we study this report the more convinced, I am sure, we are of its completeness. I therefore wish to have the privilege of making the motion that we adopt this report as the report of this association.

A MEMBER: Mr. President, I am glad to second that motion.

MR. BACON, TREASURER: I would like to say to the members of the association that the expenses of the Training School Committee has amounted to a little more than the Toronto convention voted to allow. The amount that was allowed by resolution for the work of the Training School Committee was \$500. The total amount expended for that work was \$591.95. Our President, Dr. Peters, paid the \$91.95 out of his own pocket, so as to bring the bill within the amount that was allowed by the resolution. I do not believe that the members of this association want Dr. Peters to do that, and I would like to make a motion that we reimburse Dr. Peters.

The motion being duly seconded, it was put by the Secretary and carried unanimously.

REV. DR. KAVANAGH, BROOKLYN: It is quite a remarkable fact that a report has been brought to us on this subject that has passed unanimously. When we remember the debates of the past two or three sessions, I think it almost remarkable; the fact that this committee has succeeded in bringing in a report that is unanimously adopted by a very large proportion of the members of this convention. That there is not a dissenting voice means a very able piece of work has been accomplished by this committee; and therefore I desire to move a vote of thanks to the committee for the work they have done and the report they have rendered. As there are two gentlemen on the platform who are members of that committee, I would suggest that the treasurer put the motion, if it is seconded. Mr. Treasurer, I move that we extend a vote of thanks to this committee for the splendid work they have done throughout the past year, requesting that the report be adopted unanimously.

The motion being duly seconded, it was put by the treasurer and carried unanimously.

PRESIDENT: I will confess very frankly to one thing: I feel very much better than I did when that resolution of Dr. Kavanagh's was put up to us a year ago. But, speaking seriously, the committee did work conscientiously, and it means a good deal to all the members of that committee to feel that the report has

been received with such recognition. We have been perfectly frank; we were perfectly frank and open in trying to get all the help we could from all sources at that time. Personally, it is a very great satisfaction to the members of the committee to have their action endorsed by the association. In regard to the return of the money, paid out by the president, we ran into expenses without much thought, all of us thought \$500 would be ample. We invited everybody and did all we could to get all the information on the subject possible. When we learned that the appropriation had been expended or had been exceeded, we thought best to go on and get all the information we could, without limiting the price. I thank you sincerely for your action in regard to the matter. If there is no further business the meeting will stand adjourned until tomorrow morning, 10 o'clock.

THE VALUE OF MEDICAL SCHOOLS TO HOSPITALS.

BY DR. RUPERT NORTON.

Johns Hopkins Hospital, Baltimore, Md.

During the first two years of instruction in the Johns Hopkins Medical School the students have no clinical work, and do not come into the hospital wards for any form of instruction. All their time is taken up with work in the laboratories of the medical school. At the beginning of the third year the clinical work commences and the students get their first instruction of this nature in the Outpatient Department, or Free Dispensary for the Poor, of the Johns Hopkins Hospital. The class is divided into groups, which rotate through the four principal services of medicine, surgery, gynaecology and obstetrics. In the medical and surgical departments the students receive instruction from the visiting physicians to the Hospital, and the associate physicians who belong to the dispensary staff, while in the gynaecological and obstetrical departments most of the instruction is given by the hospital residents or internes, for the number of out-patients in these two services is smaller than that in the other two, and the hospital staff attends to this class of patients, although helped in part by one or two physicians who work in the dispensary.

At the beginning of the fourth year the students commence their clinical studies, and these are more thoroughly pursued in the medical division of the hospital than in the surgical, gynaecological, or obstetrical services—partly due to a smaller number of patients in the latter two services, and partly due to the different method of instruction given by the heads of these departments. Another reason which applies to the gynaecological and obstetrical services especi-

ally is that the special examinations required in those classes of cases are of such a nature that extreme care has to be used in order not to deter patients from coming. Examination required by a gynaecological or obstetrical patient can only be made by one or two students at a time under the guidance of an older doctor and in the presence of a nurse.

To show how the work is organized, let me give you a concrete example. The class is divided into fourths, and each fourth is taken in rotation through the different services, receiving 10 weeks' instruction in each service. The students in medicine, as soon as the division has been made, are each given one or more cases in one of the medical wards to study, depending on how many cases come into the ward, the patient is allotted to the student who has the smallest number of cases under his care at the moment. As some patients remain longer in the wards than others, one student may not get quite as many new cases to study during the ten weeks as another, but usually the numbers run very nearly even, and the student averages from 20 to 25 cases during his stay on the medical side. The student is expected first to make a careful history of the patient, and then to examine the blood, urine, sputum, faeces, and to take the blood pressure if necessary. All these examinations are not made in every case, but he will receive his instructions from the medical officer in charge of the ward as to what must be done. The student is supposed to be on duty from 9 a. m. to 6 p. m., and as many of the students live near the hospital and are busy oftentimes later than that with their cases, they may secure a new case when admitted late in the evening. The students are not expected to make a physical examination unless the medical house officer is present, and no female patient is examined unless a nurse is present. In the medical wards students do not make gynaecological examinations. When the visiting physician makes his visits, he questions the special student in charge of certain cases about the patient under consideration, and goes over the entire history very carefully, criticizing, correcting and expounding the case. At these visits all the students in the medical division are present, so that they obtain a view of all the medical cases

in the wards, and are expected to study them as thoroughly as possible during rounds, listening to heart murmurs, palpating tumors, or making other observations. Each student is thus in turn critically examined as to his cases, and each student has the advantage of seeing his own mistakes corrected, as well as of seeing each of his classmates examined in exactly the same way. The visiting physicians make their rounds from 9 to 11 a. m., when every student is expected to be ready to report on his cases, and by that hour, if the patient was admitted the evening before, the complete preliminary history and examination must be ready. By 9 o'clock the patients have had their baths and breakfasts, and the ward is ready for the visit of the physicians. During rounds any student is liable to be questioned by the visiting physician about any case, and thus the whole class is kept alive and awake. The work cannot be shirked, for a student cannot escape having patients allotted to him, and must write the histories, etc. Beside this bedside work, the physician-in-chief gives a clinic once a week in the amphitheater before the entire fourth class, at which certain patients from the wards are presented, and the student under whose care they have been is called upon to present their histories. In this way different groups of cases are presented together. For instance, on one day several cases of typhoid fever, or pneumonia may be presented together, or, various forms of cancer, or any other series of cases. Oftentimes, however, these hours are used for the demonstration before the students of especially rare cases. At these clinics members of the third year are also present.

On the surgical side the work done by the students is much the same, but the surgeon-in-chief does not hold ward rounds, and the students are quizzed by him and his assistants in the surgical amphitheater once or twice a week. In the wards the students are expected to take histories, be ready to examine the urine, etc., in cases of need. They assist in making simple dressings, and also at operations, where they pass instruments and serve in positions of minor importance. During the third year the students have considerable experience in the surgical outpatient depart-

ment, and thus are fairly well prepared for the work they are called upon to do when they enter the wards.

To the gynaecological wards the students are not admitted at present, but receive all their instruction in the outpatient department, where the service is a large one; or in the gynaecological operating room, where they witness operations, but do not take part in them. The rest of the instruction is by means of lectures. In the out-patient department the students are taught how to make examinations of the pelvic organs.

The instruction in the obstetrical department is more thorough, and the students under strict supervision, and in small groups, are allowed to make the necessary internal examinations, as well as to practice external palpation and percussion. The only limitation from which they suffer in this department is its size, so that they do not have an opportunity to see a very large number of cases, but this limitation is rendered less serious by the fact that there is now a very excellent out-door service, which gives each student the means to report on at least eight cases of labor which he has attended personally. The number of patients in the hospital is limited simply by the lack of means to accommodate more patients, as our quarters for confinement cases are restricted. If it were possible to accommodate more patients within the hospital, the opportunities offered the students could not be improved upon.

As is seen from the above account the Johns Hopkins Hospital is not wide open to students to come and go as they please, but the students are under very strict supervision, and only those to whom patients are allotted are allowed to work in the wards; and, as noted, the gynaecological wards are as yet not used for student instruction. With classes of students ranging now about 75, there are not enough patients in the public wards for their really necessary instruction. Were all the public wards full up to their limit at all times, which is only the case now and then, the number of patients in an active service, such as exists in this hospital, would be sufficient in some respects, but as it is there are several of the important specialties in which our students get only limited instruction. There are

in the hospital but 15 beds for white women ill with medical troubles, and the same number of beds for white women suffering from surgical non-gynaecological affections, a much too small a number of each for what is needed for the best teaching. In the genito-urinary, skin, eye, ear, nose and throat and nervous specialties the students have little opportunity for the bedside study of patients suffering from one or the other of these troubles, as there are no special wards in the Johns Hopkins Hospital for the reception of such cases. This better than all demonstrates the limitations of the ordinary American general hospital for the instruction of students. In this respect we are far behind the best conditions existing in Europe and Great Britain, where municipal hospitals exist which have departments, *i. e.*, wards for the reception of all such classes of cases, and which are connected with medical schools, or at least where the students under the care of their instructors have the opportunity to study these cases. While we are doing the best we can at the Johns Hopkins Hospital to give the students a thorough medical education, yet they graduate without having received such instruction as they should have to make them capable general practitioners. Little by little our means of instructing them are improving, and we shall soon be able to graduate men who will know something of mental diseases, and be able, we trust, to distinguish between scarlet fever and measles in children. The Johns Hopkins Hospital rightly holds a leading position in the eyes of the public as a training school for medical students, but it only seems right to make evident its limitations in order to show what a hospital should be—that is, how many different departments a large general hospital should have that is connected intimately with a medical school, in order to graduate men who have had some experience in the observation and study of the main diseases which they are likely to meet with in general practice. For it is general practitioners we desire to turn out, not specialists. It is frequently said that the young doctor just starting in practice only sees the common diseases, and this is true in large measure, but at the same time he may any day meet with a less common trouble, and even if he can-

not diagnose it at once, he should feel that he has had the experience and training to make it possible for him to care for the patient, and not feel obliged to send at once for a specialist, or to turn the patient away. Then many of our graduates will go into the country or smaller towns to practice, and they there will meet with all sorts of cases and emergencies which they should and must be ready to handle.

This makes plain what a thorough medical education demands of the student today and what the teaching hospital should be ready to furnish. It has been stated that there should be teaching and non-teaching hospitals. There always will be, for the real teaching hospitals will only exist in the cities where there are medical schools; but here each hospital will be benefitted that is willing to open its doors to the medical student, and make use of his service. It is fair to state that there has been no complaint on the part of the patients in the wards of the Johns Hopkins Hospital as to the presence of students, and it is largely due to their presence that the numbers of patients coming annually for treatment from all parts of the country increases. It is the duty of the instructors to see that the students behave themselves in the wards, and did any student fail to do so, he would be put out of the ward at once, and would fail to graduate. Such misconduct has never occurred at the Johns Hopkins Hospital. No well-managed hospital need have any fear that the presence of students will do it injury, if the students are overseen. The existence of teaching hospitals in Europe and Great Britain has demonstrated long since that this is the best form of hospital—best for patients—best for staff, and in America we have been too slow to recognize this, and are still too hesitating in many instances. A large general hospital and hospitals for the specialties should be used whenever possible for teaching purposes. It makes no difference whether the hospital is privately endowed, or is a city institution. Private patients in private rooms which they pay for, are of course to be treated like patients in their own homes. Otherwise with proper restrictions suited to special conditions, all public patients should be used as far as possible for teaching purposes.

The patients like attention, and soon learn that the more they are studied the better they are treated, and when they return to their homes talk of their care and good attention, and so persuade others to come to the hospital. I feel convinced from my observation of conditions at the Johns Hopkins Hospital that no more patients leave us annually discontented with their treatment than occurs at other hospitals of the same size. Every hospital meets with patients who cannot be contented, no matter how much is done for them, and at the Johns Hopkins we have special difficulties to contend with in this respect, for we receive many patients who have been the rounds of other doctors and other institutions and who are here as a last resort. These are the patients whom it is hardest to satisfy. We have no more difficulty in using the white patient than the black for teaching purposes, and at our evening medical meetings, which occur twice a month, the doctors who desire to exhibit patients who have been in the hospital and left after recovery succeed almost invariably in persuading them to return for exhibition. This simply shows that the patients if treated with consideration, which should always be the case, are grateful for the care and interest shown to them, and do not mind being used for teaching purposes. I lay stress on this point to make it clear to all that as superintendents of hospitals they need have no fear of admitting students to their wards, if the visiting staff is anxious to have them, and will see that they do their work as it should be done. I cannot particularize further how the work should be done, for this will depend on both medical school, nature of hospital and staff. The only absolute essential everywhere is that the student should recognize his responsibility in being given the privilege of studying in the ward, and feel that on him the good name of the hospital in large measure depends. His name and work will probably not be known outside the hospital, but by his work others older than he will be assisted, and their work will give the institution its reputation. Without the help of the student much of the routine work now done in the Johns Hopkins Hospital would go undone. It is mere routine drudgery often-

times, but it has to be done, and it gives the older house men opportunities to pursue special lines of study.

As the student works in the ward he will acquire an interest in his patients that a student without hospital experience never or very rarely obtains. He is drilled daily in the careful observation of the patient under his care, and learns to record the condition from day to day, sometimes in emergency cases from hour to hour. He could have no better training for his future practice. The teaching of the student is also excellent for the younger internes, who have to keep their wits polished, and cannot afford to be slack in their own work if they wish to secure the regard of their pupils, as well as to prove their own ability to the visiting staff. From top to bottom, or from bottom to top, the presence of the student is a stimulus to good work by all, and the better the work, the better of necessity the care of the patient, and this is ultimately the object of all hospitals—the best care possible of the patients under their charge.

The presence of students undoubtedly brings increased expenses on the administration of the hospital, but these should be met as one of the most necessary charges. A teaching hospital requires a larger staff of nurses than another non-teaching institution, which is a very vital point in hospital administration; but no hospital has more nurses than it needs, and very few have enough, so that in the end the presence of students works good in this way. In addition to the better care coming thus indirectly from the students, better care of the patients results from the greater interest taken in them by the nurses, who, unless born naturally stupid, are stimulated by noting the careful study of the patients on the part of the students. Other charges which must be met by the hospital are such as instruments and supplies needed by the students for the ordinary routine examination of patients—scales for weighing patients, electrical batteries, ophthalmoscopes, blood-counting and pressure apparatus, etc. Such supplies have in some instances to be furnished to each ward, and often more than one blood-counting apparatus of a kind to each ward. The quantities of such supplies will be regulated by the numbers

of the students, the size of the wards and their proximity one to another. In modern teaching hospitals it is getting to be more and more common for special clinical and bacteriological laboratories to be built in close connection with each, or more than one ward. This naturally increases the cost of hospital construction tremendously, and can, in my opinion, be carried too far. Well arranged and equipped laboratories closely connected with the wards should be a part of every well built general hospital, but it is not absolutely necessary to have a reduplication of such laboratories with each ward, and there are distinct disadvantages in such a plan. A small room for the examination of urine and for blood-counting is to be recommended in connection with each ward, but larger laboratories, it seems to me, should be placed elsewhere. The tendency today is concentration, and staff officers want all their work, both ward and laboratory, closely grouped to save themselves time and exhaustion in walking from one part of the hospital to another, but the time so saved in a well constructed hospital, and the fatigue of walking should not be great. It is well, too, to oppose the modern impulse to rush everything, and to make everything easy for students—to give them a surplusage of laboratories; to supply them with elevators for going up and down a single flight of stairs is not necessary. I do not wish to stand in opposition to real progress, but for every individual staff officer to have his own complete set of laboratories seems to me an extravagance, where one large laboratory building or suite of rooms will serve equally well. Concentration of laboratories should be considered quite as much as concentration of laboratory and ward. These are expenses which are required and which will pay for themselves many times over in the long run. The presence of students necessitates a larger staff of internes, and this again brings increased cost to the hospital in furnishing them with board, lodging and washing.

I fear I may have frightened some of you by this list of burdens brought to a teaching hospital by the presence of students, but the satisfaction of having the students when you have once tried them, will outweigh all the difficulties

of the situation, and I trust I have made clear to you the great advantages for them and for us it is to have them in daily contact with the patients.

DISCUSSION

PRESIDENT: This subject, so ably and interestingly presented is open for discussion. We have a good many members here who are connected with teaching hospitals, and we would be very glad to hear from them.

DR. JOS. B. HOWLAND, BOSTON: From the Massachusetts General Hospital point of view, I should say that its practice is very similar to the Johns Hopkins Hospital. We do have the students in the wards under similar control to the Johns Hopkins, and certainly our conclusions are the same as his: "That students in the wards are a benefit to the patients and to the hospital." I cannot remember a complaint in the last three or four years referring to the presence of students, or a protest on the part of any patient, either free or paid, stating that they do not wish to have the students examine them. They feel that the more they are examined, the better attention they get, and when they go out they state that they have had these examinations from all these physicians and students.

REPORT OF THE COMMITTEE ON HOSPITAL PROGRESS.

By DR. R. R. ROSS,

*Superintendent Buffalo General Hospital,
Buffalo, N. Y.*

In presenting this paper, I find it necessary in a large measure, to confine myself to general principles. To attempt to take up and discuss many of the newer questions, would consume far more than my allotment of time. If I can present such items of interest as will enlist your lively discussion I will feel repaid for my effort.

Hospital boards of managers are giving more attention than ever before to the selection of their executive officers. Until a few years ago, the average superintendent consisted either of a man who had made a failure of everything he had attempted, or a woman who knew nothing of business principles. The management selected the chief executive officer for one of these classes either because his services could be cheaply obtained, or because it was thought that an act of charity was being done in giving the recipient something to do—that he should have any knowledge of the needs of the sick was not considered a requisite. Hospital construction, ventilation and heating were left entirely in the hands of the architect, or with men who had had no experience with the needs of patients. His chief duties were to purchase such supplies as were asked for, hire and control the help and see that three regular meals were served each day. To stand in a closer position to the hospital than this there was no need. If a careful survey is taken of the changes in the position of superintendents in hospitals, both large and small, for the past year, one cannot help coming to the conclusion that boards of trustees are showing a keen appreciation of the importance of having a well trained officer to administer the affairs of their institutions.

The problems of administration are many times greater than they were a few years ago. Hospital sociology, path-

ological laboratories, the care of tubercular patients, the increased private room service, open-air treatment, etc., all call for a more experienced and expert service. No one can appreciate the truth of this statement more fully than the one in the central department, where sooner or later all issues must touch. The time no longer exists when a man can conduct independently any institution to a successful issue. He must keep in touch with institutions doing a like kind of work, and be alive to the rapid changes going on in medicine and surgery.

It is probable that nowhere in the world is there so much money spent on hospitals, in proportion to the number of patients treated, as in the United States, and it is probable that nowhere is there such an overlapping of interest as in our own country. In a paternal government such as Germany, the government says how many and what kind of hospitals shall be built in a given locality, and what the capacity of these hospitals shall be and the kind of work they shall perform. With us a given locality may be having its needs properly cared for by a well established institution, and yet, through the zeal of another school of philanthropists, a location is selected within one or two blocks, and an institution of a similar character is built. No regard is paid to the ratio of hospital facilities to the population, and the real object of a hospital is lost, or, better, has not been discovered.

The new institution is started, mortgaged to the limit and for scores of years must continue to furnish mediocre facilities both to patients and doctors, due to the lack of funds to properly equip and carry on a legitimate, up-to-date work; an inferior grade of service must be tolerated for the same reason. A hospital is primarily built for the care of patients. Without them none of the lines of hospital work such as the training of doctors and nurses, original research and the collection of data useful to physicians, can be carried on. If a hotel is to be built, a location which will cater to the needs of the public is selected. The same business acumen should be displayed in locating hospital. There seems to be prevailing opinion among the profession that a hospital should be conducted

along lines entirely different from those of any other business, and this is just where the medical and lay boards so many times disagree. It is impossible to convince a director, or even the average layman, who has made his money by putting into effect in his business, thorough and business-like principles, that the same methods are not applicable in running a hospital. Is it more than natural that he should expect the same care used in the expenditure of his donations as he used in collecting his funds.

"The domination of the dollar is no mistake, because without it no institution can live." There is nothing peculiar about hospital people, they need food, clothing and shelter the same as others. It is the subservience to the dollar that is a weakness. In my judgement, every hospital patient should be represented by cash or its equivalent. I do not mean by this that the hospital should exclude the deserving poor because he cannot produce the funds to pay his weekly bills, but I do mean that the community should see to it that the hospital does not lose one penny by reason of the destitution of the patient. This can be cared for in a variety of ways—by sufficient endowment, by annual donations and by taxation. There is no equity or justice in following the idea, that because a man or woman gives unstintingly of his time and energy to the management of the institution's affairs, that he should be compelled to make up, from his own pocket, funds to meet deficiencies. I know of men who would be valuable on any hospital board, but who hesitate because they feel that they would not be able to meet the demands which would be made upon them should they accept office. I think I hear some one asking how are we to obtain endowments and donations. I will grant this is a hard problem, but believe that there is a way and that if we do our work thoroughly now, future years will have the reward of our labors.

The hospital has, in the main, been a closed corporation, and comparatively little of its needs or its successes has reached the public. I know of one hospital which has for the past year employed a press secretary, whose business it is to see that all legitimate hospital news reaches the public, nothing, however, concerning individual patients is allowed

to reach the news agencies. Needed improvements, or improvements in buildings, the need of new features, such as isolation accommodations, sun rooms, laboratory facilities, addresses at commencement exercises cost of caring for patients and many things of like character are reported. The object is to keep the hospital and its work continually before the public. Hospital news is probably as thoroughly read as any item in the daily press. In many cases it is only the kicks of patients written up by reporters with a vivid imagination, or glowing head lines announcing a bequest of five or ten thousand dollars which the public sees. The result is that it soon comes to believe that the hospital is a cruel, inhuman place, a place of the last resort and yet heavily endowed. The business man does not hesitate to tell the public of the good things he has to sell, and I believe it entirely ethical for the hospital to present its advantages in an attractive manner, and in such a way as to encourage confidence in the public and a knowledge among patients that their interests are being carefully guarded.

The needs of the community hospital should be recognized by every citizen, and every one should be educated to feel that he owes a certain amount of his energy to the state and its institutions, which make it possible for him to enjoy his home in safety, in peace and happiness. The politician, the merchant, the manufacturer, all recognize the advantages of publicity. Why should not hospitals avail themselves of some of the same advantages?

Hospitals, although they have existed for centuries, are of comparatively modern growth. The primary object was actuated by most humane thought; today it is becoming an economic question. The hospital field is increasing in enormous proportions. In the past ten years the number of hospitals and the work performed in them has doubled. In many there is a tendency to drift away from the real object of the institution. There is a condition arising which both the lay and professional boards will be compelled to meet. With the increasing number of apartment houses and family hotels, the quiet of the home with its many advantages disappearing, conveniences and accommodations

for sick members of the family are becoming less desirable, and patients who once preferred to remain at home now seek admission to the hospitals. These patients often wish to retain the services of their own physician, whom they think the best in the community, and whom they prefer to all others.

In many hospitals I find there seems to be an effort made to encourage the family physician to come to see patients whom he has sent to the wards of the hospital, much can be learned from him concerning family history of the patient, and the staff certainly has much which it can give, useful to the busy practitioner. The patient is also much encouraged and helped by the visits of the one whom he feels has his welfare at heart. Some provision should be made whereby these patients may have the advantages of the hospital and the services of their own physicians. One hospital in a city of considerable size has lost materially, because patients of this class were refused admission unless treated by the regular staff. Financial help was withdrawn and the statement made that if the hospital were run in the interest of a few doctors, the sooner the public knew it the better. I am informed that at a recent meeting of physicians in Chicago, the hospital question was freely discussed. Some doctors claimed that their treatment in hospitals was so unsatisfactory that wherever possible they preferred to keep their patients at home. It was claimed that internes and nurses neglected the outside physician and his patient, and made odious comparisons as to the methods pursued in the presence of patients. The hospitals are probably pursuing the easiest course in having all patients treated by their own staffs, but are their benefits reaching the numbers they should? The growth of hospitals calls for a wider knowledge of their various needs. Specialism in the medical profession has come to stay, and I believe justly so. Just as the idea that one man can give his best thought to all the ills of man has become obsolete, so the idea that a single ward can care for the diseases of the eye, nose and throat, gynecology and general surgical diseases, or a medical ward where pneumonia, tuberculosis, typhoid fever, rheumatism, etc., can be treated, must pass

away. One disease does best in a cold out-of-door atmosphere, such as pneumonia, while a patient with rheumatism suffers under like conditions. In hospitals recently planned there is a decided tendency to the smaller wards and greater isolation.

At the meeting two years ago and again last year, it was suggested that some provision be made for the training of those who are to engage in hospital administrative work. Grace Hospital, Detroit, and the Massachusetts General Hospital, Boston, have each conducted courses along this line. The applicants have far exceeded the accommodations for such students, thus demonstrating that such a course was practicable. The United States Government has also during the summer conducted a school for the training of those who are to engage in hospital executive work in the war department. Columbia College, N. Y., has for the past year given a course in hospital economics. The popularity of these courses indicates that there is a demand for them. I think you will all agree with me in the statement that little has been done in past years of the association work which was of practical use to the members, outside of the papers, addresses, discussions and fellowship. I have a suggestion, which, if carried out, would, I believe, be of material use to the members. I refer to a central bureau, where would be filed plans of all new buildings erected or improvements in old buildings. This could be easily done if there was some paid help in the secretary's office.

Plans of private patients' building, executive building, wards, offices and laundries could be filed in classes or so indexed as to be easily found, any hospital board or its representatives to have free access. Interested persons would by this plan have grouped for them all that is latest and best in hospital construction. It would also be possible to carry the work much farther, such as explaining kind of construction, etc.

In this connection it has occurred to me that a list of the houses where articles of certain kinds and grades could be best purchased, together with prices, would be advantageous. This could be gotten up in such a form as to be easily mailable to any person wishing the information.

I am sure all will feel repaid for attending these meetings, but if more can be obtained and knowledge can be better classified and rendered more assimilable the advantages will be even greater. I wish to urge the establishment of a central office with a competent paid assistant to the secretary, some of whose duties will be those enumerated above.

During the past year much attention has been given to tubercular and isolation hospitals. In fact the majority of hospital effort has been directed along these lines, which is entirely in keeping with the efforts of the medical profession. In most states of the union there is an awakening to the ravages of tuberculosis and states, cities, and municipalities are establishing hospitals and sanatoria for the isolation and care of patients suffering with this disease. These institutions include both permanent buildings and day camps. The latter are places where patients who are able to, can go and spend the day in the open air and sunshine, and receive such food and medicine as are indicated. Patients who would be injured by going to and from their homes daily, receive night accommodations. At the camp, with which I am most acquainted, patients are served three regular meals daily, with extra nourishment consisting of milk and eggs between meals. They also are given careful instructions in the care of sputum and personal hygiene. Several cities during the past year have either erected hospitals for contagious diseases or made appropriations for them. Philadelphia has just partially completed a large plant at a cost of one and one-half million dollars. This institution is complete in itself, having its own nurses' home, laundry, kitchen, ambulance stable, etc. Providence has also completed an institution along similar lines. The Homoeopathic Hospital in Boston has also erected a building for contagious cases at a cost of \$300,000, and for the same purpose, Buffalo has during the past few months made liberal appropriations both for a tubercular and contagious hospital, both of which are to be complete and entirely separate institutions.

The city just mentioned has had an experience during the past winter which has fully demonstrated the need of contagious hospitals. Its population is 400,000, and for

several months about five hundred new cases of scarlet fever were reported each month. The city was without a contagious hospital, and with the exception of a few small isolated buildings connected with the general hospitals, containing but a few beds, there was no place where these patients could go. Home quarantine was attempted, but no progress was made in stopping the spread of the diseases till an old school building was taken for a hospital, where an effectual quarantine could be carried out. Soon after this was opened for patients it was noticed that the number of new cases rapidly diminished, thus demonstrating that to establish an effectual quarantine there must be a place under proper control where cases may be sent.

On the 9th of June, the convention of National Association of Charities and Corrections was held in Buffalo. Many interesting topics were discussed, and among them was hospital sociology. We were told that our work was only half done by our present methods. Various schemes were proposed, and follow-up systems were suggested. It was also proposed that each hospital have its own organization. Numerous examples were cited to show the advantages of hospital sociological work. The writer is in entire sympathy with anything which will relieve suffering, but could not help being impressed with the idea that soon the independence and responsibility of the individual for his own welfare will no longer be needed. It is perfectly proper to use every effort to teach the poor man how to make the best possible use of his scanty income, in order that it may bring the best results to himself and family. No well informed person doubts for a moment the wholesome results derived from sleeping with open windows and a free circulation of air, but with a temperature of zero and no woolen blankets for the poor man to protect himself and family, and only a small fire in a kitchen stove, problems are introduced which require greater philanthropy than the giving of advice. No doubt if ignorance was removed the independent classes would be much benefited. This has many times been abundantly demonstrated. Poverty, however, is the most potent factor with which the social worker has to contend. As soon as the family becomes more prosperous many of

the social ills disappear. If, then, the earning power of the family can be increased the social condition will surely improve. When the husband's earnings are small, the wife has to supplement by her daily labor, and with continuous tired bodies there is little incentive to put the home in the best sanitary condition, or practice the higher arts of the culinary profession.

No one who has the milk of human kindness in his heart can fail to be touched by Miss Wadley's little monograph, entitled, "A Glimpse of Social Service in Hospitals." A vast field of work, hitherto untouched, has been opened up. Hospital sociology, undoubtedly has a great opportunity, and several institutions have already accomplished most gratifying results. There must be, in order to obtain best results, means to provide the needed relief which the worker will surely find. All those who have had any experience in institutional work know that good ventilation means good sized coal bills. It is rather hard to establish a new order of things without supplying the means to carry it out. I am also of the opinion that there is a tendency to unnecessarily multiply organizations. The C. O. S. Society, a stable organization, is well supported, and in many instances is willing and able to take up the work where the hospital leaves it. The hospital is only a link in the general chain of charity—let that link be made strong and enduring. In large manufacturing plants, one group do a certain part of the work, another takes it where the first leaves it, and carries it a step further toward completion, and so on till the finished product is reached. For any one individual to attempt to follow an article from beginning to end would be contrary to all accepted views of modern methods. Is not some such scheme applicable to our charities, and thus prevent overlapping, which sometimes occur.

During the past years hospitals have been able to practice more rational methods in ambulance work. A bill providing for a board of ambulance control in New York City was signed by Gov. Hughes, May 19th. This board is to consist of the Police Commissioner, the Commissioner of Charities, the President of the Board of Trustees of Bellevue and Allied Hospitals, and two appointees by the Mayor.

This, I believe, to be the first systematic effort to place ambulance work under proper control. Hospitals have hitherto been left largely to their own initiative to provide relief for the injured or actually ill. This, while being carried on with the interests of the hospital at heart, has resulted in frequent overlapping. The ambulance service effects the whole city in which it is given, and should be so directed and controlled that the best results may be attained. It can therefore be readily seen that ambulance work should be under some central body, as much as the police, the health or educational departments. I am informed that many institutions of that city have removed the gongs from their ambulances, thus compelling the drivers and ambulance surgeons to conform to the ordinary usage of the street. It was believed that this would have a tendency to diminish accidents. Whether the results anticipated have been realized I am unable to say. Hospitals have found that the spectacular run of the ambulance does not impress the public favorably. The only possible excuse that can be offered is that the hospital, if short of patients, is likely to have two instead of one. At the Buffalo General Hospital the practice of running through the streets was only stopped after the discharge of one or two drivers, and the new ones informed that if the practice was continued they would meet the same fate. There is nothing more unjustifiable than seeing two ambulances racing for the same patient; there is not only danger to pedestrians, but also to drivers, surgeons and horses, besides a waste of charitable funds. The dependence of the average hospital on public charity is too great for any money to be wasted in this work or in possible lawsuits, as has sometimes occurred.

Mr. Thorne, Treasurer of the Presbyterian Hospital, New York City, a man whose experience entitles his views to be received with favor, has proposed a scheme by which the hospitals of New York City can save many thousands of dollars. His proposition is that the hospitals form an association for the purchasing of supplies. That each pay a certain amount as yearly dues, this amount to be in proportion to the yearly expenditure. That a central office and warerooms be established, with the necessary purchasing

agents, clerical help, etc. This same plan is used by many of the railway and steamship companies, and if one may judge from the experience of business corporations, it seems to be a move in the right direction. If the scheme is applicable to hospitals in New York City, why is it not practicable to include others, especially those within reasonable proximity? Competitive bidding would undoubtedly be very close when large contracts were involved. The smaller institutions would gain more than the larger ones, for their supplies are bought in smaller quantities and the dealer usually charges a proportionately higher price. By the scheme proposed, if I am correctly informed, all would be able to secure the bottom price.

Dr. Cabot is credited with the following statement: "Physicians generally are placing less and less reliance on drugs." The doctor has plotted a curve, showing the decline in the use of drugs at the Massachusetts General Hospital. This curve covers a period of fifteen years, and the rapidity of its descent is striking. Fifteen years ago the annual cost of medicines for each patient was about \$2.90; last year it was 91 cents. The cost of drugs in the Buffalo General Hospital for the past year has markedly decreased. It is difficult to predict what the future of medicine in hospitals is going to be. Undoubtedly drugs will continue to be used, but other agencies, whether they be psychotherapy, Fletcherism, Chittendism, or some agency still unknown to us, will have a place. There will perhaps be doctors to preach and pray, doctors to prescribe the correct methods for the use of the mind, specialists on fresh air and exercise, and doctors to prescribe drugs and operate. These statements may seem to be in lighter vein, yet hospitals are beginning to adapt themselves to the changed conditions.

There has been in many hospitals a lack of team work. It is doubtful whether a business institution could be made to survive for any period of time with the frequent disagreements we see over policies in hospitals. A group of men in the lay board have certain fixed ideas, another group of the staff who think they have equally as just claims, see matters quite differently, and to harmonize all interest is, at times, a difficult problem. It is unjustifiable

for any board to feel that the best work can be carried out effectively and on the highest plane, without the best medical and surgical skill on the staff, and it is equally as great a fallacy for the medical staff to presume that it is the whole thing; that the trustees are of minor importance. The truth lies where it so often does in like cases—both have their sphere of usefulness and should in all fairness respect the work of each other. If you will take the care to go over the founding and maintaining of hospitals carefully you will find that the layman has always played the prominent part. The trustee has nothing to gain from his connection with the hospital, save the satisfaction of doing for his unfortunate fellows. He does not increase his clientele or business acumen: not so with the medical man, for not infrequently it is his making. It gives him a prestige. It gives him an opportunity to do scientific work, an opportunity of becoming a teacher, which would not otherwise come to him. Horace Mann said that he would rather have one performer than a dozen reformers, a statement which I think exceedingly applicable to hospital workers. The result is that any group of men through conference reach the best one of that group. Individual initiation means that for a time you have to submit to the worst of such a group." In a recent book published by Mr. Allen, he makes the statement that hospitals do too little bookkeeping. I take issue with him in this statement in regard to some institutions, but I also know it applies to others. Each hospital should know and be able to tell the public in plain language what hospital service costs, by so doing it is possible at times to tap resources of popular support, which will be of material help. The hospitals of New York State reported last year deficiencies aggregating over one-half million of dollars and some reported spending \$22.00 per week on ward patients. There seems to be no limits to expenditures and to the thoughtful observer the idea must occur as to whether money so spent is doing all the good it should. There seems to be a sentiment growing that hospitals are reckless in expenditures. The daily press in some cities has made charges that in some institutions physicians have held private monopolies. I contend that

if such expenditures as have been paid are justifiable and other charges are untrue, that the hospitals have no right to remain supine and allow philanthropists to believe that they are badly managed and that henceforth they will make their gifts to charities more carefully supervised. Hospital work should be given full publicity, providing that the interests of the patients are properly safeguarded and medical ethics are in no way violated, for an uninformed public is a fickle friend.

There has been in times past too little attention paid to the resources of an institution. It will do for a time to go on running up debts and large deficiencies, but a reckoning day comes. Men do not like to be connected with an institution which is a continuous drag, and, on the other hand, are willing to help a good thing along. It is easy to get funds to put into a prosperous business, and the same applies in the hospital field of work. There should be frequent and friendly meetings between the various heads of hospitals, where matters can be discussed. The trustees, the staff and executive should have conferences where the resources of the one and the needs of the other may be considered. There is no need of being discouraged if at first this seems to meet with little success, for it is possible that each will need educating in the other's field of work. Too much censorial criticism of men and methods is of doubtful value. Each should regard the other as being honest of purpose and trying faithfully to discharge his duties. It has been with hospitals, as it has been with many other organizations or governments, difficult to break away from established customs and traditions. Things are many times allowed to continue because they have always been so and any change of method or procedure is condemned before a fair trial is given. The surgeons, the physicians, the internes, and the nurses, all have important duties to perform, all bring something, and many of them much. It must, however, not be forgotten that all receive and that the hospital is entitled to, and it is to their interest to give it loyal support, recognizing in it charity work so far as it is possible, its financial limitations and humane obligations.

Finally I wish to take a moment to bring to your attention a matter which, with all our new efforts along the sociological work, open air treatment and other things of modern enterprise, is likely to be neglected. I refer to the proper care of incurable cases. Most hospitals are willing to throw wide the doors to the acutely ill and many brilliant results are recorded, but the poor man or woman with an incurable disease, has not received the attention he should. If he is so fortunate as to be allowed to remain in one of our modern hospitals, his case is turned over to the inexperienced interne and nurse. Little attention is given by those who should be in a position to help the most. Too frequently he is passed by as one for whom nothing can be done, and attention given to the more interesting case. Much can be done to relieve the physical pain and much more can be done to relieve the mental suffering. If any one needs sympathy and help, it is the incurable. A little sunshine, a cheerful word, a kind good morning will do much to smooth the way. Remember that whether your hospital is crowded or not, that service is not always reckoned in brilliant results, and that a great act of charity may be done in caring for him whose last hours are crowded with physical pain and mental suffering.

DISCUSSION

A MEMBER: Do I understand Dr. Ross in his paper to claim that he would advocate the open hospitals—that patients should be attended by their own physicians? There was one paragraph in his address that struck me as tending in that direction, and I would like to know whether he advocates the open hospital. In other words shall the hospital wards be open to all physicians?

DR. ROSS: I advocate that private rooms in a hospital should be open to any reputable physician who wishes to attend patients there; that the patients who apply generally to the hospital for care and treatment should be under the care of the regular staff; that there should be some provision made for the middle class between these two, who wish to retain their own physician. We have what we call a semi-private ward, that is a little above the public ward, and not a private room, and there we allow physicians to attend their own cases. There is no doubt of the fact that there are many patients who wish to retain their own physicians,

and many times the physicians are good physicians, too, and the patients have more confidence in them than they would have in a complete change of doctors.

A MEMBER: In the case of that semi-private ward, where the patient has his own physician, does he pay the actual cost of his care in the hospital?

DR. ROSS: He pays the actual cost or the figure that is the basis of actual cost.

REV. DR. KAVANAGH, Brooklyn: I think that an increasing number of our hospitals are making such provision. Some time ago I was led to investigate hospitals in the Borough of Brooklyn and Manhattan, and I was surprised to find that many of the large hospitals in the Borough of Manhattan had methods by which they extend the privileges of the hospital to outside physicians. One of the largest hospitals in Manhattan—one of the wealthiest, one of the hospitals doing the best work in the city today—had a list of between forty and fifty men outside their regular staff, but not published in their annual report, who had the privileges of the wards of the hospital, and the semi-private rooms. I was surprised to find that very conservative institution had recognized this particular demand and made this provision. I also found that almost all of the other hospitals had some such provision, though perhaps not on as large a scale. That led us to open our private beds, our semi-private as well as our private rooms, to the outside physician. The superintendent passes upon the question of permitting the outside physician to use the private bed until the meeting of his executive committee. At the end of the month he reports all such cases. If by any accident or any mistake an unworthy physician is permitted the use of a private bed, his name will be eliminated, and he would not have the opportunity again. But so far, although we have been practicing that plan for some time, the executive committee has not found it necessary to revise any of the rulings of the superintendent with regard to the admission of such physicians; and in that way we think we are doing a just thing in dealing with the physicians generally, as well as in many ways protecting the interests of our own staff.

REPORT OF COMMITTEE ON UNIFORM ACCOUNTING.*

BY DR. GEO. F. CLOVER.

Supt. St. Luke's Hospital, New York City.

So far as has been ascertained from examination of the annual reports of various hospitals and institutions, seventeen such are now using the system originally adopted by three of the New York hospitals, the details of which were promulgated through the generosity of the Treasurer of the Presbyterian Hospital, New York. Of these, twelve are located in New York, one in Boston, one in Jersey City, one in Brooklyn, and one in Yonkers, one in Hartford having adopted it with some modifications. It has been learned that several other hospitals are now keeping their accounts in accordance with the system, and will so report at the time of publishing their next annual statements. Thus, in the three years since the subject began to assume definite form, considerable progress has been made; yet, in review, one can not but wonder why the adoption has not been more general. The system is well planned, adaptable to the needs of all institutions, and as simple in its working as any comprehensive method of accounting can be. Its advantages to the management are manifold, its disadvantages but few. Among the most important of the former is that of checking expenses through comparison with other institutions. Several of the hospitals are now exchanging their statements monthly, and from this exchange, I, personally, have derived the greatest benefit. Comparison between individuals may be odious, but comparisons between institutions, especially in the matter of expenditures, are generally helpful and directly tend to economy.

*Read by Dr. C. H. Young.

As a matter of policy also, the method is a distinct advantage. The people who aid in the support of our voluntary hospitals do not make their gifts without discrimination. They are looking into the work performed by the hospitals and the manner in which they spend their money. They want to know that the trust is well and properly executed. Referring to this very matter, a man of note recently wrote in an article published in one of the periodicals dealing with the subject of charities:

"Personally, I believe that every community may be relied upon to support generously every hospital that is needed, provided it has the confidence that the hospital management is both intelligent and economical in the true sense of the word; that is to say, that it seeks efficiency without waste, even though the greater efficiency be costly. I am very sure that nothing will contribute so much to the development and maintenance of such a feeling on the part of the public as the knowledge that the management of every hospital itself knows in detail exactly what everything costs, and that it is checking its own work by the results obtained by others under conditions more or less similar."

The disadvantages, on the other hand, are chiefly imaginary, and will be dissipated by spending a few dollars for a set of books and keeping them according to the plan outlined in the pamphlet portraying the system. It has been said by those interested in hospitals doing a special work that no fair comparisons can be made between the hospital which they represent and another, because of the nature of their service, such phrases as the following being encountered: "We, for instance, care for surgical patients only, and, therefore, our expenses are proportionately larger;" and again, "The cost of supplies in our locality is greater than in most places. For these reasons we do not care to publish our statements in a manner that will invite unfair comparison." In my opinion, these persons are aggrandising the imaginary difficulties and losing the great advantage that would revert to themselves through a detailed comparison with other institutions doing a similar work. If supplies do cost more in a certain locality,

that fact is so well known as hardly to deserve mention. If a hospital is caring for surgical patients only, a simple statement to that effect will quickly obviate any misapprehension that may arise in the mind of the thoughtful public.

In the matter of details, there is nothing that presents itself to me looking towards change or improvement. There is one thing, however, I think deserving of emphasis, and that is in connection with what is termed "Current Expenses from Special Funds for State Purposes." Here, moreover, is to be found an answer to another objection that has not infrequently been urged against a uniform system. Hospitals frequently have funds given them, or bequests left them to provide for some charity, or some procedure unusual in the average hospital and non-essential in hospital routine. To illustrate what I mean: we have at St. Luke's a foundation for the burial of those dying at the Hospital leaving no relatives, or only those in needy circumstances; a fund for drives in the park for sick children; another fund to provide a voice to sing to the praise of God in the Chapel and wards; and lately a large bequest has been received to be used for pathological studies and research. Other hospitals have foundations not identical in purpose with these, but which come in the same category of special funds, and on which the general hospital work is in no way dependent. For the sake of correct comparison, the income and expenditure of these funds should be separately exhibited, and the expenditures should not be included in the per capita expense of the hospital. This treatment of such funds, while indicated in the pamphlet, is not, I think, closely followed by some of the hospitals that have adopted the system in the main. It would, in my opinion, be advisable for all institutions to report on their special funds of the character described are apt to have them multiply in number and, if the expenditures from these funds should be exhibited in the per capita expense, such expense in these hospitals would see disproportionately large. In the Johns Hopkins Hospital, for instance, which is doing such a large educational work in connection with the Medical College of the University bearing the same name, the

expenditures for material used by the students must be very large; if these expenditures are, or should be included in the per capita expense, it would be both unjust and absurd to make comparison with any hospital not doing educational work. If matters of this kind are kept in mind and the distinctions as to the work being done by different institutions be exhibited in the reports, there need be no fear that comparison will ever be unjust.

In conclusion, please permit me to urge that every member of the Association who has not done so will seriously consider the subject of Uniform Hospital Financial Reports and Statistics. I firmly believe that if it receives the consideration it deserves the system will be generally adopted; and furthermore, I believe no one will be disappointed in the result.

FIRST ANNUAL CONFERENCE,

THE ASSOCIATION OF AMERICAN HOSPITAL SUPERINTENDENTS.

Organized at Cleveland, O., Sept. 12 and 13, 1899.

The meeting was called to order by Jas. S. Knowles, Superintendent, Lakeside Hospital, Cleveland, O.

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Lakeside Hospital, Cleveland, O.

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Hotel Schenley,

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THIRD ANNUAL CONFERENCE,

ASSOCIATION OF AMERICAN HOSPITAL SUPERINTENDENTS,

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ASSOCIATION OF AMERICAN HOSPITAL SUPERINTENDENTS,

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City Hall.

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Ninth and Tenth Annual Conference

NINTH ANNUAL CONFERENCE.

AMERICAN HOSPITAL ASSOCIATION.

CHICAGO, ILL.

Palmer House

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INDEX.

Amendments to By-Laws.....	91
Auditing Committee, 1908-09 & 10.....	4-7
Accounting, Uniform, Report of Committee on.....	426
Auditing Committee, By-Laws	89
Address of President.....	138
Address of Greeting.....	94
Architect and Doctor in Planning a Hospital, Relationship between	305
Arthur, Lieut.-Col. William, Address of.....	153
Auditing Committee, 1909, Report of.....	107
Administration of Military Hospitals.....	153
Alphabetical Membership List	9
Appropriation of Public Funds for the Partial Support of Vol- untary Hospitals	242
Arizona, Members residing in.....	44
Aikens, Miss Charlotte A., Letter from.....	101-132
Assistant Nurses, Training of, Report on.....	378
Arthur, Lieut.-Col. Wm., Letter from.....	104
Amendments to Constitution and By-Laws, suggested.....	
.....108, 109, 110, 124, 125, 126, 127, 128, 129, 130, 131	
Ambulance Chasers	119
Brush, Dr. Frederick, Address.....	181
Business, Order of.....	91
By-Laws, Amendments to.....	91
By-Laws	87
Bratenahl, Rev. G. C. F., Invocation.....	92
Clinics and Demonstrations, First Year.....	369
Clinics and Demonstrations, Second Year.....	371
Constitution and By-Laws, 1908, 1909, 1910, Committee on.....	4-7
California, Members residing in.....	44
Canada, Members residing in.....	45
Colorado, Members residing in.....	48
Connecticut, Members residing in.....	48
Cuba, Members residing in.....	49
Constitution	85
Committees, 1910	4-5-6-7-8
Clover, Dr. Geo. F., Address of.....	426
Committee, Time and Place of Meeting, Report of.....	133
Cost Accounting in Hospitals.....	193
Corwin, Dr. R. W., Address of.....	295

Conference, First Annual.....	430
Conference, Second Annual.....	430
Conference, Third Annual.....	431
Conference, Fourth Annual.....	431
Conference, Fifth Annual.....	432
Conference, Sixth Annual.....	432
Conference, Seventh Annual.....	433
Conference, Eighth Annual.....	433
Conference, Ninth Annual.....	434
Conference, Tenth Annual	434
Davis, Dr. F. E., Letter from.....	100
Development of the Association, 1908-09, Committee on.....	5-89
District of Columbia, Members residing in.....	49
Discipline of Members.....	91
Dues of Members.....	89
Duties of Officers.....	87
Education for Nurses, What do Justice and Present Conditions Demand in the Way of Law and Education for Nurses.....	345
Elections, By-Laws	87
Emerson, Dr. Chas. P., Address of.....	305
Executive Committee, 1908-09 and 10.....	4-7
Executive Committee, By-Laws.....	88
Fees, Surgeons'	121
Florida, Members residing in.....	50
Folks, Homer, Address of.....	166
Georgia, Members residing in.....	50
Goldwater, Dr. S. S., Address of.....	242
Guests at Convention.....	90
Greeting, Address of.....	94
Hawaiian Islands, Members residing in.....	51
Honorary Members	84
Hospital Progress, Committee on, Report of.....	411
Hospital Efficiency, Finances, and Economics of Administration, 1908, 1909 and 1910, Committee on.....	5-8
Hospital Construction and Management.....	295
Hospital Progress, Committee on, By-Laws.....	89
Hospitals, Small, in Proximity with Large, Training Schools in ..	373
Hospitals, Isolated Small, Training Schools in.....	367
Hospitals, Large General, Training Schools in.....	375
Hospitals, Special, Training Schools in.....	374
Handbook on Hospital Management.....	101-132
Hospital Information, Special Committee on.....	8
Hospitals from the Patients' Point of View.....	160
Hospital and the Public.....	176

Hospital Work, Many-Sidedness of.....	166
Hospital and Patient of Moderate Means.....	181
Hospital Construction, Report of Committee on.....	333
Howard, Dr. H. B., Address of.....	333
Hurd, Dr. Henry M., Question Box.....	111
Illinois, Members residing in.....	51
Indiana, Members residing in.....	53
Invocation	92
Instructors, Paid, in Training Schools.....	120
Iowa, Members residing in.....	54
Kansas, Members residing in.....	54
Kentucky, Members residing in.....	54
Lectures and Demonstrations.....	370
Louisiana, Members residing in.....	55
Massachusetts, Members residing in.....	56
Maine, Members residing in.....	55
Maryland, Members residing in.....	55
Members, Honorary	84
Membership List, by States	44
Membership List, Alphabetical, 1909-1910.....	9
Membership Committee, By-Laws.....	89
Membership Committee, 1908-9, Report of.....	105
Membership Committee, 1908-09 and 10.....	4-7
Medical Schools to Hospitals, Value of.....	401
Meetings of the Association, By-Laws.....	87
Military Hospitals, Administration of.....	153
Michigan, Members residing in.....	60
Minnesota, Members residing in.....	61
Missouri, Members residing in.....	63
Mississippi, Members residing in.....	63
Municipal Hospitals, Private Rooms in.....	117
Naval Hospital in North Chicago, Description of.....	318
Nebraska, Members residing in.....	64
New Hampshire, Members residing in.....	64
New Jersey, Members residing in.....	65
New South Wales, Members residing in.....	66
New York, Members residing in.....	66
Nominating Committee, By-Laws.....	89
North Carolina, Members residing in.....	74
North Dakota, Members residing in.....	75
Nurse Assistants, Special Committee on.....	8
Nurses, Training of Men.....	119
Nominating Committee, Report of.....	125
Officers, Duties of.....	87

Officers for the year 1910.....	3-6
Ohio, Members residing in.....	75
Oklahoma, Members residing in.....	76
Order of Business.....	91
Oregon, Members residing in.....	76
Pavilion, Terraced	217
Pennsylvania, Members residing in.....	76
Peters, Dr. John M., Address of.....	138
Phelps, Dr. R. M., Address of.....	345
President, Address of.....	138
President, By-Laws	87
Probationers, Qualifications for Admission as.....	366
Preliminary Course	368
Publication Committee, 1909-10.....	8
Proceedings, Publication of.....	90
Purchasing Agency, Central.....	118
Question Box	111
Rhode Island, Members residing in.....	80
Rixey, Surgeon-General, Preston M., Address of.....	94
Ross, Rear Admiral, A., Address of.....	318
Saracen, Dr. D., Address of.....	217
South Carolina, Members residing in.....	80
South Dakota, Members residing in.....	81
State Membership List.....	44
Sutton, Del. T., Address of.....	176
Secretaryship, Permanent, Committee on.....	8
St. Louis, Place of Next Meeting.....	133
Superintendents, Meetings of with Boards of Trustees.....	114
Terraced Pavilion	217
Tennessee, Members residing in.....	81
Texas, Members residing in.....	81
Training School Committee, Report of Special.....	361
Thompson, Dr. W. Gilman, Address of.....	160
Treasurer, By-Laws	88
Treasurer, Report of.....	107
Utah, Members residing in.....	82
Uniform Accounting, 1908-9-10, Committee on.....	5-8
Uniform Accounting, Report of Sub-Committee on.....	426
Vacuum Cleaning, Discussion on.....	111
Virginia, Members residing in.....	82
Vermont, Members residing in.....	82
Washington, Members residing in.....	82
West Virginia, Members residing in.....	83
Window Shutters	118
Wisconsin, Members residing in.....	83

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960 House of Delegates
A6 Proceedings. Annual con-
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